MARYLAND
STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

1211 CATHEDRAL STREET, BALTIMORE 1, MARYLAND

Official Publication of the Medical and Chirurgical Faculty of the State of Maryland

VOLUME 3 | *October, 1954* | NUMBER 10

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THE MARYLAND STATE MEDICAL JOURNAL

Editorial and Business Office, 1211 Cathedral Street, Baltimore 1, Maryland

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THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

Secretary's Office, 1211 Cathedral Street, Baltimore, Maryland

Entered as second-class matter at the Post Office at Baltimore, Md. Acceptance at the special rate authorized

Single Copies, 50¢ *Subscription $3.00 per year*

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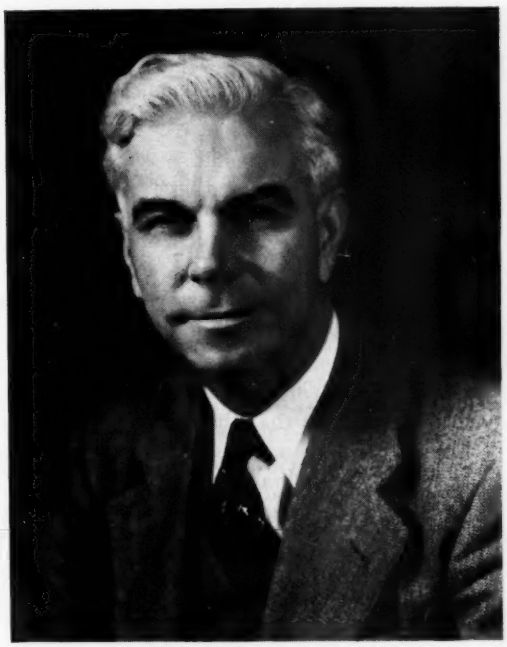
EDITORIAL—The Library's Importance

LOUIS KRAUSE, M.D.*

To grow up in an atmosphere of books is indeed a privilege. Those who have had this opportunity should be ever grateful. There is something friendly about books; they appeal to the emotions, possibly even more than to one's intelligence.



DR. LOUIS KRAUSE

Books, like friends, are constant, and never fail us. As we grow older our libraries become a greater source of comfort to us, because we realize that we are joining the older generation. One turns to his books to learn of the past, to get ideas or

*Chairman, Library Committee, Medical and Chirurgical Faculty of the State of Maryland.

opinions of the present, and to look for signs of what the future may bring. Patrick Henry's statement is very true: "I know no way to judge the future but by the past." The farther in the past we can look, the farther in the future we can see.

The founders of New England were a practical people whose first thought was their defense, their second: "that good learning should not perish from among us." The maintenance of a well-equipped library should be an important enterprise of any city. In a medical center, a superior library should be an obligation. A college and medical school training are an excellent thing, but the better part of every man's education is that which he acquires by himself. A good library should furnish the opportunity and the material. One is haunted by Koheleth: "And, further, by these, my son, be admonished: of making many books there is no end; and much study is a weariness of the flesh." Today, cataloging in the libraries has become almost a science, and stacks of books are no longer a labyrinth. One finds guideposts at every turn in a well organized library. While this help does not imply a shortcut to learning since that is impossible, it does, however, offer a shortcut to information that will make learning more accessible. Every book we read should become a rung in the ever ascending ladder by which we climb to knowledge. A profitable way to spend time is to browse in a library. One cannot limit the joys of the infinite treasure of books. "If you approach them, they are not asleep; if you question them, they conceal nothing; if you mistake them, they never grumble; if you are ignorant, they will not laugh at you."

Most of us in medicine are craftsmen, and books in great measure are our tools. It is therefore, important for us to have adequate tools, improving them as the frontier of knowledge advances. Much of our knowledge today is the result of our increased precision in our tools. For this reason, I believe the support of the medical library is very necessary. It is distressing to see how frequently the practitioner ceases to continue his medical education after he is graduated. Fortunately, this is becoming less true as postgraduate instruction is increased. For those who are not interested in supporting a large reference and consulting library, it is imperative that they have their own library. However, this is not often the case. Only too frequently the material appurtenances of living are stressed, but a well used library helps to keep life sweet as we grow old.

One can readily distinguish between the doctor who is keeping one foot in the library and is constantly in touch with the current medical literature, as contrasted to the doctor who has little or no interest in medical literature. Throughout the ages, one sees landmarks of medicine being made by the doctors who are interested in their practice, and in medical literature.

The Medical and Chirurgical Faculty at its outset dedicated itself to the improvement of its members. This certainly was the spark or germ that initiated the collection of books that we have in the library.

There is need for a place where all members of the medical profession can obtain easy access to any medical literature, where the latest medical information can be displayed. Nothing illuminates a people like scholars, and a library surely

helps to produce them. Certainly a physician of common sense without erudition is better than a learned one without common sense, but the thorough master in his chosen field must have learning in addition to his natural gifts. It is a short sighted policy to maintain books of only practical utility. Our book shelves should contain many volumes that will be used only by a certain class of medical scholars. It is very true that there is a dead medical literature and a living one; the dead isn't all ancient, nor the living all modern, and there is none living or dead which cannot teach something, even as an autopsy teaches medicine. It is with the living literature that the medical practitioner is first concerned. Thus a library to meet the needs of our time must subscribe to a great number of periodicals in our own and other languages. Such a large number of periodicals no private library would have need of nor wish for. This certainly will bring about an opportunity for a well rounded knowledge. Isn't it disturbing to hear constantly in our present culture, the flippant wisecracks and half knowledge bandied about? We must accept whatever good that may be obtained from it, but to use the old imagery, we must keep it under control as we do weeds in a lawn by enriching the soil and sowing good seed in the form of good teaching and good books rather than wasting our time talking about it. Half knowledge can only be conquered by whole knowledge.

The periodic journals are not the only important kind of writing. Much of what is in a journal is crude and unsound. Only too often many of us remain under the influence of the last article we have read as a woman under the sway of the latest fashion. There is a difference between seasoned and unseasoned knowledge. So, it is well to have both kinds available. The shelves of our library must offer the greatest hospitality to a variety of subjects. Some books have written words of wisdom of the framework of the time in which they were written, but have ceased to be oracles. Some never had any important burden. Apart from any practical value of older writings isn't it a pleasure to read the accounts of great discoverers in their own words and language and their problems? Many an ancient volume is of practical value and will never grow old. There comes a time when every book in the library is wanted by somebody. A few days ago a celebrated physician and author in another country asked for books on a certain subject. It was with great satisfaction that he was referred to our collection. Our shelves must also extend space to a class of works which we consider outside the purview of modern medicine. I refer to the various cults, such as the Adventists, spiritualists, and are they not worthy of our philosophic study? True they belong to a class of minds with which we must be patient while their Maker sees fit to grant their existence. With all their skill, our practitioners need a library like ours. Our liberal profession could still use more erudition. This would be reflected by the public; no one will deny that the public needs more instruction on the subject of health and disease. How frequently we see the people victimized and preyed upon by every kind of imposition. The ignorances and prejudices of the populace react upon the profession to the harm of both.

Our Medical and Chirurgical Faculty Library is peculiarly equipped with information about the local history of the medical profession in Maryland. How

comforting it was for our Library Staff to supply the history of the early days of medicine for counties in the past year, to wit—Dorchester and Montgomery! It was a source of inestimable satisfaction to the Staff. This local history was not to be had in the Library of Congress or the Army Medical Library.

Our Library then is like a temple that should be consecrated as a cathedral dedicated to the advancement of sound knowledge and the study of man, his physical, mental, spiritual and social natures. This will increase our efforts to relieve suffering, to promote a good public relationship with each member of the profession and the public with special emphasis for those who are promoting the well being of their fellow men. We certainly can restate the ancient proverbs:

"Receive my instruction, and not silver; and knowledge rather than choice gold. For wisdom is better than rubies; and all the things that may be desired are not to be compared to it."

"And they that be wise shall shine as the brightness of the firmament; and they that turn many to righteousness as the stars for ever and ever."

Reports

THE SAN FRANCISCO CONVENTION

HOWARD M. BUBERT, M.D.*

For a novice delegate, participation in a convention of the American Medical Association is a revealing, impressive, and arresting experience for several reasons. The first is the tremendous size of the entire affair, which gives one almost a feeling of awe—not only of the meeting itself—but of the power and size of an organization capable of such an effort.

A.M.A. Convention Headquarters, San Francisco, California, 1954

The 1954 annual meeting held this year in San Francisco was the 103rd of the Association, and the eighth and largest held in that city. There were 12,063 physicians registered, of whom 148 were from outside of the United States. The total registration exceeded 34,000, including families of the physicians registered, nurses, medical students, exhibitors and other interested persons.

The scientific exhibits numbered 222 and were varied and wide in scope. About 300 papers were presented to the general and special meetings and some of these, as we all know, attracted wide interest in the public lay press.

* Dr. Howard M. Bubert and Dr. Warde B. Allan are the delegates who represent the Medical and Chirurgical Faculty in the House of Delegates of the A.M.A.

Little purpose would be served here in discussing the details of the meeting because these have been adequately covered in a series of articles that have appeared in recent weeks in the *Journal of the American Medical Association*. Using my own experience as a guide, it seemed to me that it might be worth while to explain the organizational operations of the Association because rarely do members who have had no official connection with The Association "see the wheels go around." This was to me highly instructive and I trust will be interesting to the readers of this JOURNAL.

When one attends an A.M.A. Convention as a member of the House of Delegates, it soon becomes apparent that this group represents the hard central core of the entire organization just as Congress does in the government of this Country. Obviously it would be impractical for any legislative group to have administrative responsibilities; consequently a rather elaborate administrative structure has been evolved over the years—a structure designed to implement and carry out the policies and decisions of the legislative group.

The House of Delegates consists of representatives from the component state societies as well as the Canal Zone, Alaska, Hawaii and Puerto Rico. The sections also have delegates as do the Armed Services and the Public Health Service.

The first obligation facing the delegate is the establishment of his credentials and this is done very quickly so that the House can begin work promptly, which is a prime necessity because of the great volume of resolutions and reports that must receive consideration in the limited period of time available. The body is under the extremely able leadership of the Speaker, Dr. James Reuling of Bayside, New York, assisted by his equally able associate, Dr. Vincent Askey, of Los Angeles, Vice-Speaker.

As the meeting gets organized and underway it soon becomes evident that—like the United States Senate —it is a club even though not "the most exclusive one in the world," and many of the members are back after having served previous terms and having made contacts and friendships that are so essential if a member of a legislative body is to be an effectual representative of the organization which sent him to the meeting. One soon becomes impressed with the fact that he has joined a body of serious, intelligent and competent men intent upon doing a good job.

The Speaker, Dr. Reuling, soon impresses one with his efficiency, his knowledge of parliamentary procedures, his good humor and his grim determination to fight the clock and complete the business of The House as expeditiously as possible. Some conception of the task that he faced is gained when one considers that ninety resolutions were offered for consideration, a few of which were highly controversial and capable of arousing considerable emotional response upon the part of both proponents and opponents. This work load, of course, did not include the reports of the Board of Trustees, the different Councils, the officers, and speeches by the retiring and incoming presidents.

There was a strict rule that all resolutions must be in the hands of the Secretary before the sessions began and, needless to say, this was honored in the breach by many: causing the speaker to say rather ruefully, "It is only a pious hope that this has been accomplished."

Each resolution and report was referred by the Speaker to an appropriate "Reference Committee" for careful consideration, following which they reported back to the House, giving a discussion of each together with recommendations. These were usually followed. This is a particularly important phase of the plan of operation of the House, because by segmentation time is saved and small informal hearings are possible. Anyone interested in any particular phase of the work is free to appear before the reference committee concerned and present his views, thus insuring a forum for all.

The writer was impressed by the fact that the senior delegate from Maryland, Dr. Warde Allan, had over the years obtained the respect and liking not only of the Headquarters staff but also of the members of the House of Delegates, and that he was becoming an increasingly valuable representative from our State.

The National Organization wields a tremendous influence on the national scene, particularly as regards Washington, which now plays such a dominant role in our daily life. Because the number of delegates from a state depends upon membership—one per thousand or fraction thereof—Maryland actually should have three instead of two if more members belonged to the A.M.A. This seems a "must" to me and I believe all of us should assist in attaining our full representation so that we may have the greatest voice possible in the affairs of the Association.

COMMITTEE FOR THE STUDY OF PELVIC CANCER*

BEVERLEY C. COMPTON, M.D., *Secretary*

Abstracts of Case Discussions:

1. S. L. Colored. Age: 46 years. Widow. Para 1. Bilateral salpingectomy and appendectomy at age 20 years. Periods always somewhat irregular. For the past two years very heavy flow, and for the past year many clots. Intermenstrual bleeding for about one year before coming to the hospital. Consulted doctor A late in 1951—pelvic examination made—treated with oral medication, medicine for "nerves," etc. Told that she was having the menopause. Patient remained under care of doctor A until May 1952. June 1952, consulted doctor B. Pelvic examination made. Patient told that she had a fibroid tumor and that she was in the menopause. The patient states that she consulted doctor B every 2–3 weeks. Because of the persistent intermenstrual bleeding, patient was referred to the hospital in October of 1952.

Diagnosis: Squamous cell carcinoma of the cervix, I. C., stage I.

Treatment: Radium 4320 mgm. hours. Deep x-ray therapy.

Chairman: From the information we have there appears to have been delay on the part of doctor A and also doctor B. Although pelvic examination was made and the patient found to have a fibroid, the history of intermenstrual bleeding should have been indication for further investigation.

Visiting physician: This patient was first seen by me on June 23, 1952. A complete physical including a pelvic examination was done at that time. She had a large fibroid uterus. There was no lesion visible on the cervix and the report sent to me by the hospital indicates that no lesion was visible at the time of their first examination in the clinic. It has been my experience that patients with myomatous uteri often have irregular bleeding. The patient had told me that in 1950 she had some irregular bleeding following a normal period and that a diagnostic D. & C. had been done at that time at another hospital. Because the irregular bleeding persisted and because the patient herself had a fear of cancer I referred her to the hospital in late September, 1952. The hospital reported that the lesion was an early one.

Chairman: I think the only criticism here is that one should be very careful in assuming that the cause of irregular bleeding is a fibroid. It is fortunate that the diagnosis was made in this case while the disease was still early. We use the classification "delay" if there has been a lapse of more than one month from the time the patient consulted a physician until the diagnosis is made or the patient referred for further study.

Visiting physician: You mean "delay" because the diagnosis could have been made earlier?

Chairman: That is right.

Committee member: It is interesting that this patient had a diagnostic D. & C. in 1950. The patient apparently did not give this information in her history at the second hospital. It would be interesting to look up this record.

(The record of this operation was subsequently checked. A D. & C. and biopsy had been done in January of 1949. The pathological report of the biopsy was *Carcinoma-in-situ, cervix.* Every possible effort was made at this time to get the patient to return to the hospital for further study but she refused although the situation was fully explained to her. Because of the above findings, the case was presented at a later meeting as of interest because of the lapse of time between the original diagnosis and treatment, and the fact that the case was still a stage I at the time of treatment. Review of the original slide of January 1949 had confirmed the diagnosis of carcinoma-in-situ.)

2. K. B. Colored. Age: 34 years. Widow. Para 2. Periods said to be regular. No intermenstrual bleeding. Patient first seen in gyn. clinic in 1945 for chronic P.I.D. Seen in September 1948, July 1949, January and February 1952, for exacerbations of P.I.D. Several visits to the clinic May–November 1953, with complaint of incapacitating pain, recurrent. It was recommended that the patient have a pelvic clean-out. She was admitted to the hospital December 1, 1953. Biopsy of the cervix revealed carcinoma, which was classified as stage I, early. A modified Wertheim hysterectomy was recommended. At operation, December 9th, a bilateral salpingo-oophorectomy was done but the uterus and cervix were not removed because of question of right broad ligament involvement with carcinoma. The pathological report: "Fibrous tissue with slight chronic inflammation, right broad ligament—no tumor." The patient was subsequently treated with radium and deep x-ray therapy.

Committee member: This cervical carcinoma was picked up on routine biopsy on admission to the

* Under the auspices of the Medical and Chirurgical Faculty and the Maryland Division of the American Cancer Society.

hospital. It is the routine procedure that a cervical biopsy is done on every patient scheduled for hysterectomy. The sections showed very early stromal invasion and although it is not the usual procedure at this hospital to treat a stage I by operation, it was felt that this was a very early lesion and that a modified Wertheim was indicated. At operation a wide band of inflammatory tissue was encountered and it was decided that the wiser course was to remove only the tubes and ovaries. It was felt that if this was carcinoma it could not be cured by operation. If it was not carcinoma the cervix could be treated equally well by radiation. When the pathology was found to be negative, the patient was treated with radium and deep x-ray therapy.

Visiting surgeon: Not as a criticism but as a point of interest, had any biopsies been taken during the time the patient was followed in the clinic?

Committee member: I am sorry that I do not have the complete hospital record here today but it is my impression that biopsy had not been done previous to hospital admission. The cervix appeared negative.

Visiting surgeon: I do not feel that there can be any criticism of the treatment in this case. Too often a total hysterectomy is done even though the cancerous process is found to be more extensive than was thought pre-operatively, and then there is nothing left to work with.

All present at the meeting agreed that in view of the findings at operation, the procedure followed was the wise choice.

3. L. B. Colored. Age: 50 years. Married. Para 0. Menopause, 1949. January 1952, patient began to have moderately profuse whitish vaginal discharge and intermittent spotting which gradually increased in amount. Consulted doctor A in February 1952. Pelvic examination made. Patient told that she was having "the change." Treated with injections of penicillin. As the symptoms persisted and increased, the patient consulted doctor A about once a month for four or five months—was examined and assured that symptoms were due to the menopause. October 1952, spotting or moderate bleeding daily, and dull lower abdominal pain. December, bleeding became more profuse and patient went to the hospital clinic January 14, 1953.

Diagnosis: Epidermoid carcinoma of the cervix, I. C., stage III.

Treatment: Deep x-ray therapy. Radium.

Chairman: Is there any further information available on this case?

Committee member: Our information is substantially as given in the abstract. The lesion was far advanced when first seen in the clinic.

Chairman: There appears to have been considerable delay in this case. The patient was first seen by a physician in February of 1952 but was not diagnosed until January of 1953. Without much doubt this year made the difference between stage I and stage III. Apparently in this case repeated pelvic examinations were made but the diagnosis missed.

4. C. S. Colored. Age: 58 years. Married. Para 5. Supravaginal hysterectomy 24 years ago. Patient known to have had high blood pressure for some time—under care of doctor A because of this. Late December 1953, following a fall, patient had an episode of moderate vaginal bleeding. Reported this to doctor A—pelvic examination made and said to be negative. Continued to have slight bleeding about one day a week. Beginning in February, a white vaginal discharge. Reported the continued bleeding and discharge to doctor A, and told him that she had heard this sometimes meant cancer. He advised the patient to go to the hospital clinic. Because of various family problems the patient did not go to the clinic until May 12, following an episode of rather profuse bleeding.

Diagnosis: Carcinoma of the cervical stump, I. C., III.

Treatment: Deep x-ray therapy. Radium.

Chairman: Doctor A is unable to attend the meeting today but we have the following information from him:

The patient first complained of vaginal bleeding, following a fall, in November 1953. She was not examined at this time because she was bleeding. When she returned later in the month she was not bleeding and a pelvic examination was made which revealed an "eroded-looking cervix but nothing definite." No medication or treatment. The patient again complained of bleeding in February of 1954 when examination revealed a lesion definitely suspicious of malignancy and the patient was advised to go to the hospital. She was seen several times during February in regard to blood pressure and was again advised to go to the hospital.

Committee member: Here again we have a case where the patient was not examined because she was bleeding. In this case the patient returned without too much delay and was examined although the malignancy was not detected. Even though the examination appeared negative, at least a Papanicolaou smear would seem to have been indicated.

Had this been done the patient might have come to treatment earlier.

Committee member: This situation where a woman is not examined because she is bleeding is one of the things that comes to the attention of this Committee most frequently. We have discussed it many times but can emphasize again that this is never a reason for not examining a patient.

Chairman: There was certainly a large element of patient delay in this case—a delay of almost three months from the time she was advised to go to the hospital until she was seen in the clinic. There also appears to have been some delay in referring the patient for further investigation.

5. C. W. White. Age: 49 years. Married. Para 2. Beginning in the summer of 1952, periods irregular. January–September 1953, no regular periods but very slight spotting about once a month. Patient's chief complaint during this time was extreme nervousness. She consulted doctor A at frequent intervals. Symptoms said to be menopausal. Patient treated once a month with injections. Late September 1953, very profuse bleeding and the patient was sent into the hospital for biopsy. Referred to second hospital for treatment.

Diagnosis: Squamous cell carcinoma, cervix, I. C., stage IV.

Treatment: Deep x-ray therapy. Radium.

Chairman: We have written to doctor A for further information regarding this patient but unfortunately we have not received a reply.

Visiting surgeon: Our history is about as given in the abstract. The disease was very far advanced, with involvement of the bladder, at the time the patient was referred to us for treatment.

Committee member: From the information we have it appears that the patient was treated over a rather long period of time without complete examination, on the assumption that the symptoms were menopausal. However, the patient was sent into the hospital promptly at the time of the first episode of profuse bleeding.

6. M. L. White. Age: 33 years. Married. Para 3. Periods always somewhat irregular. April 1953, brownish vaginal discharge and vulval itching. Consulted doctor A—Papanicolaou smear and biopsy taken. Biopsy said to show intraepithelial carcinoma. Repeat biopsies, May 22nd and June 26th, were also interpreted as showing intraepithelial carcinoma. The patient was referred to the hospital clinic and admitted to the hospital, July 13th, for sharp conization. On July 15th, the patient had a panhysterectomy. Pathology at the time of operation: Chronic cervicitis with focal basal cell hyperactivity and one focus suggestive but not fully characteristic for carcinoma-in-situ.

Chairman: There is, of course, no question of delay here. This is another case where a very early carcinoma was picked up promptly. The patient was followed closely and all the right things seem to have been done. Is there any further information.

Visiting surgeon: This is one of our cases. The pathology at the time of conization showed basal cell hyperactivity and the pathologist felt that the patient should have been followed for a longer time before surgery. The gynecological staff, however, felt that all evidence seemed to point to carcinoma-in-situ and we went ahead with the panhysterectomy.

There was discussion of the diagnosis and treatment of carcinoma-in-situ.

DRAFT BOARDS TOLD TO RECHECK RESIDENCY DEFERMENTS

A. M. A. Washington Letter, No. 79

The National Advisory Committee to Selective Service is concerned because some young physicians, deferred the past 12 months for residencies and internships, are delaying application for commissions. Involved are priority 1 and 2 men and those in priority 3 who are 31 years or under. These groups, the committee has informed selective service, are most urgently needed to meet calls for this fiscal year to avoid calls on priority 3 men over 31. Adds the committee: "It is essential, with few exceptions, that those who do not apply for commissions should at least have their 2-A classifications terminated." This would make them eligible for immediate induction.

Scientific Papers

THE HERNIA PROBLEM:

The Role of the Internist and General Practitioner

AMOS R. KOONTZ, M.D.*

My first operative case, when I started in the practice of surgery, was that of an elderly gentleman with a hernia, who was referred by a close friend and classmate of mine. The patient was a friend of us both. Imagine my chagrin when the hernia recurred a few months later. Naturally, the patient was discouraged and never had another operation.

What was the cause of this failure in a comparatively simple inguinal hernia? I believe that there are two reasons for it.

In the first place, I am sure that at that time, without realizing it, I treated the hernia in a rather casual manner, as a great many people do. This in spite of the fact that Halsted had been my professor of surgery in medical school, although I had not had my hospital training under him. I had operated on many hernias during my surgical residency, but had not had an opportunity to follow them up. This first private case, however, was a lesson to me and never since have I been the least bit casual about any hernia repair, but have constantly been seeking more knowledge as to the cause of hernial recurrences, and have been applying all the knowledge I could get as meticulously as I could at the operating table.

Undoubtedly another reason for the failure in my first case in private practice was the fact that this elderly man had had his hernia for a great many years and that operation had never been advised until it became strangulated, which was the case when I operated upon him. Not only was the hernia strangulated, but with the long period of time and the advancing years, the patient's tissues were not as good as they would have been had he been operated upon years earlier. He had been wearing a truss for ten years.

The operative repair of hernia in well trained surgeons has now advanced to the point that it is no longer the main factor in the hernia problem. What then is the main factor? I believe that the answer is *delay*. Why isn't such a factor easily eliminated? I believe that the trouble lies with the average doctor who first sees the patient with a hernia. It is true that many of them immediately send their patients to a surgeon. It is also true that many of them do not. Some treat the hernia with indifference and say, "Oh, you have a hernia. Why don't you get a truss?", and then do not even bother to see whether the patient's truss is properly fitted or not. Others say, "Oh, you have a hernia. You may have to have it operated upon some day but you needn't bother about it now."

Just recently a man of 26 was sent to me by one of our leading general practitioners. The patient had a postoperative hernia of twelve years' duration in a McBurney incision. A loop of bowel was out in the hernia sac and the hernia opening was only large enough to admit the end of the index finger. Fortunately the patient had always been able to push the bowel back. However, such a hernia is the type most likely to become strangulated. Yet before this patient was finally sent to a surgeon by a doctor who realized the implications of his condition, he had been seen by

* Assistant Professor of Surgery, The Johns Hopkins University School of Medicine.

three other doctors, all of whom advised against operation. One of them even had said to him, "Don't bother it until it bothers you." It could be contended with some justification that such an attitude borders on malpractice. As a matter of fact, the attitude is the result of a lack of knowledge of the hernia subject and this is astounding when one considers how common this ailment is.

It should be pointed out that *now* is the time to operate on any hernia. When they are first discovered, they are generally easy to cure. The longer they go, the larger they get and the more contracted and thinned out become the tissues surrounding the defect. A great many of the patients treated in the casual and offhand manner indicated above are young or middle-aged men. A great many of them go until they reach the 70's or 80's and then the hernias become so large and the tissues so relaxed, that they cannot be retained by trusses. Partial intestinal obstruction and threatened strangulation often supervenes. Thus, these patients are forced into operation at an advanced age when they are not in as good a condition and when the hernias are much harder to cure. Besides they have gone through many years of discomfort when they could have had an early operation and have avoided all those uncomfortable years.

Some of the internists and general practitioners who have this casual attitude towards hernia are among our very best doctors. Why then the casual attitude? In the first place, I do not believe that the subject of hernia is properly taught in the average medical school, although I believe that the instruction is improving yearly. Certainly there is still room for improvement. In the second place, a great many doctors are averse to operations unless they are absolutely necessary. So are we all. The question is when are they absolutely necessary. Considering how simple the operation for early hernia is and the many things that may happen to neglected hernias, it is my feeling that the operation for hernia is a *must* in the early stages unless there is some real contraindication. The contraindications, with the many greatly improved methods of modern anesthesia, are now few and far between.

There are some indications for operation for hernia which are more urgent than others. For instance, if the patient has an inguinal hernia which has been incarcerated once, even though it may eventually slip back by itself or be pushed back by manipulation, the condition may occur very soon again and at the second incarceration strangulation may occur necessitating an emergency operation. After one such warning, the operation should be performed as an elective procedure, as emergency procedures are never as satisfactory, even under the best conditions, as elective operations.

Femoral hernias should be operated upon as soon as possible after they appear. About 40% of femoral hernias become strangulated sooner or later and the mortality rate is high in strangulated femoral hernias, because gangrene quickly ensues due to the rigidity of the environs of the femoral canal (1).

Ventral hernias of all sorts (incisional, umbilical, and epigastric in particular) should be operated upon early, as they tend to get larger, and when they are large they are difficult to cure. In these hernias Shelley (2) found a recurrence rate of 16.8%. Burdick, Gillespie and Higinbotham (3) reported an even less satisfactory experience. Barrow (4) states that when these patients have to have a second operation, they are five times as hard to cure as at the time of primary repair.

There have been many papers in the last few years (5, 6, 7, 8, 9, 10) to show that elderly patients stand elective operations about as well as middle-aged patients, but that they do not stand emergency operations anything like so well. Certainly, therefore, hernias in elderly patients should be operated upon as elective procedures. They do very well indeed, in spite of concomitant ailments. Stewart and Alfano (11) have recently pointed out that these patients should have adequate surgical care not merely to save life but also to relieve discomfort and disability.

SUMMARY

1. Too few doctors tell their patients in the prime of life, as soon as the diagnosis of hernia is made, that they should be operated upon as soon as they can conveniently arrange it. If that were routine practice, complications of hernia would be rare and the recurrence rate would be materially reduced, because hernias would come to operation early when they are relatively easily cured.

2. Early elective operations should be performed on femoral hernias due to the high incidence of strangulation with its attendant high mortality rate.

3. Elderly patients stand elective operations well, but tolerate emergency operations poorly. Therefore, their hernias should be operated upon before they have an opportunity to become strangulated.

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OTOLARYNGOLOGY IN GENERAL PRACTICE

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It is an established fact that acute diseases of the upper respiratory tract account for a large percentage of the patients of general practitioners and also those of pediatricians. It is my purpose in this article to give helpful suggestions until someone finds a cure for the common cold.

First let us consider ordinary acute rhinitis which is the precursor of most respiratory complications. After considerable trial and error I'm sure each has a pet treatment for this condition and one is probably as good as the other. However, let me make a few suggestions. Do not employ antibiotics until signs of secondary involvement appear and these signs are easily recognized. The use of such antibiotics will mask the recession or progression of the infection. Frequent cases of chronic infection of the nasopharynx as well as chronic serous otitis media have sprung from premature treatment with antibiotics. It has been my experience that the use of antihistamines with or without the usual Aspirin-Phenacetein-Codeine combination is most effective in most cases of acute rhinitis. Once started they should not be discontinued for at least three days. Of course, bed rest, a well heated room, increased fluid intake, etc. should be established. If the nasal membranes become too congested, the local application of hot steam towels to the face at intervals is very effective in obtaining relief.

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When colds and upper respiratory infections constantly recur, the general health of the patient must not be neglected. Excessive intake of carbohydrates seems to make one more susceptible to colds. Hygienic conditions should be thoroughly checked. Forced draft heating systems should be inspected as children playing on the floor are frequently subjected to blasts of dust filled hot air. Persons susceptible to colds should keep their bedroom windows closed at night and the heat turned off. The room should be aired daily.

A mother might tell you that her child has a profuse watery discharge from the nose, that it is worse at night, and that the nose becomes very stuffy and the child coughs most of the time it is in bed. Suspect an allergy and take away any fuzzy dolls or toys that may be in or near the bed. An antihistamine at bedtime will frequently alleviate these symptoms until a diagnosis is made.

There are many conditions which present persistent subacute, recurrent, or chronic rhinitis with constant swelling of the nasal membranes and a purulent or mucopurulent nasal discharge. Such conditions occur in simple mucopurulent rhinitis, sinusitis, nasopharyngeal infection with obstruction, and infection superimposed on an already present nasal allergy. All of these conditions may be present at the same time.

Sinusitis

Severe sinusitis may be easily diagnosed by headache, pain and tenderness over the involved areas, mucopurulent drainage into the nasal vestibule, and often associated with an increased temperature, general malaise, etc. What can you do for an acute sinusitis? One of the best and simplest methods of relieving the pressure and therefore the headache, and to promote drainage is the local application of hot and cold compresses alternately to the face with equal intervals between the compresses. A sudden change from hot to cold is painful to the patient. I suggest the use of hot moist compresses for one half an hour, a half hour interval, and then cold moist compresses for the next half hour. This should be repeated constantly throughout the waking hours. I do not like "nose drops" because they cannot possibly reach all the nasal membranes and all the sinus ostia. A good fine spray is much more efficacious. I frankly do not believe it makes any difference what nasal medication you use as long as the astringent is mild and the patient is not sensitive to any of the prescription's ingredients. The astringent may be combined with sulfa, penicillin, neomycin or any of the accepted combinations now available on the market. These preparations have some bacteriostatic as well as decongestive action. However, it has not been proven that an appreciable amount of any nose spray or nose drops enters the paranasal sinuses themselves. Therefore, they merely decongest the nasal membranes, promote better drainage from the sinus ostia and keep down nasal bacterial count. A prescription for intranasal medication should be isotonic, buffered, have a pH of 7.0 or less, and should not irritate the nasal membranes. There should be a minimum absorption of the effective constituents and minimum incidence of sensitivity reaction. It should not contain oil. If the preparation causes a "stinging or burning" sensation it should be discontinued. It is much wiser to use simple normal saline than to cause irritation of already inflamed nasal membranes.

There are several nasal medication preparations which I consider excellent. They are mild and cause no side reactions such as nervousness. They are good astringents, and are believed not to cause a rise of blood pressure. Examples are Vasoxyl, Rhinalgan, Aramine Sulfate, and Neosynephrine. They may be used for children as well as for hypertensives.

The systemic use of chemotherapy and/or antibiotics should definitely be employed in all cases of sinusitis. I think it wise to abstain from using antibiotics as much as possible. I find the use of the triplesulfas, Gantrisin, Bio-sulfa and such preparations which have a wide bacterial spectrum, to be very effective. Penicillin alone does not produce as good results unless given in large continued doses. When these preparations are used, I strongly urge that they be given in sufficiently large dosage and for a period of at least four days. I have seen many cases of sinusitis flare-up because these drugs were used only for a day or two. If the patient's headache, pain, etc. persist in spite of the above treatment, he will unquestionably require mechanical drainage of the sinuses.

If you suspect that an allergy is present in conjunction with the sinusitis all of the above therapy should be used. The best intranasal medication in this case would be Drilitol or preferably Biomydrin. Antihistamines should also be administered. When

the sinusitis has subsided the allergy should be proven or disproven and treated, if found present. Allergy is frequently the underlying etiological factor in recurrent sinusitis, and a factor which should never be overlooked.

Nasopharyngitis

Infection of the nasopharynx gives rise to more complications than involvement of any other part of the upper respiratory tract. It is one of the most difficult problems for the general practitioner to treat. Infection here can cause pain in the mastoid area by irritating the vidian and petrosal nerves. It can cause pain almost anywhere in the face by irritating the fifth nerve through the sphenopalatine ganglion, and also cause pain in the throat, coughing, and dysphasia by irritating the ninth cranial nerve. Most cases of chronic progressive deafness and otitis media, as well as persistent low grade fevers arise from involvement of this area. Infection of the nasopharynx and the pharyngeal walls associated with a postnasal discharge, is often the causative factor in prolonged unproductive cough and in recurrent or chronic bronchitis.

Chemotherapy and/or antibiotics should be given. Local treatment should be similar to that described under sinusitis. For cases which are not acute but are persistent, the local use of Furacin Nasal Solution Plain, Pickrell's Solution, or Chloresium Nasal Solution are excellent. If the condition continues to resist all therapy or complications arise, more definitive measures should be initiated. Cultures and sensitivity studies should be obtained in all cases of upper respiratory infections and their complications whenever possible, so that the proper antibiotic may be chosen at the onset of therapy.

Many cases of recurrent or chronic nasopharyngitis are due to excessive or infected lymphoid tissue in this region and will not subside until this tissue is removed or treated with radium. I have not experienced much success with roentgen ray treatment of this condition.

Otology

Infections of the external auditory canal are treated in a similar manner to skin infections. There are a multitude of preparations on the market today which are advertised as "sure cures" for external otitis, but I find the Burrows Solution Pack is still very effective, supplemented with the local application of heat. This pack should be changed daily. If the infection is mycotic and not bacterial, a pack saturated with Cresatin and Thymol (five grains to the ounce) and changed daily, gives excellent results.

Before treating external otitis, be sure there is no otitis media associated with it. If both conditions are present it would be preferable to refer the case to an otologist. There are times when the swelling about the auricle is so pronounced and the periaural tissues are so tender, that it becomes difficult to differentiate between external otitis and mastoiditis.

Acute otitis media should be treated via three approaches—the external auditory canal, the nasopharynx, and the vascular system. Auralgan or Otodyne are good decongesters and pain arresters and are most effective when applied to the tympanic membrane at hourly intervals. A decongestent with or without other drugs should be used in the nose so as to reach the eustachian tube orifice. Chemotherapy or antibiotics should be employed systemically. If the tympanic membrane gives any evidence of fluid under pressure in the middle ear, a myringotomy should be done without delay. Frequently pain in, and even some slight tenderness over, the mastoid area may be noticed with acute otitis media. If the mastoid symptoms do not subside readily, then further consultation is in order.

After the pain and temperature in acute otitis media have subsided, the tympanic membrane should be observed frequently. It should return to its normal appearance in two or three weeks. If it remains dull or has any residual discoloration, an otologist should be consulted. He must then check for further pathology and instigate therapy. Failure to do this will frequently lead to early deafness, especially in children.

Quite frequently, especially in rural areas, a general practitioner has to perform a myringotomy. The following are a few suggestions which I feel will be of value when carrying out this procedure:

Be sure that the patient's head is held perfectly still or you may destroy a large portion of the tympanic membrane and/or cause trauma of the external auditory canal. The incision should be made in the posterior inferior segment and from below, upward. Do not make the incision from above, downward, or you may accidentally hook into an ossicle and

tear it loose. Be sure to make an incision and not just a stab. If the fluid which escapes from the middle ear is serous or serosanguineous, it is usually not necessary to use local medication. If it is purulent, Aureomycin Otic, Terramycin Otic, alcohol and peroxide, or one of the many preparations made for local use should be employed. If discharge from the middle ear does not cease within two weeks, more definitive treatment is indicated.

Recurrent otitis media, persistent slight diminution of hearing, and chronic otitis media, belong in the field of the otologist.

Acute Laryngotracheo-Bronchitis

This is a frightening condition for both the patient and the patient's family. It usually occurs at night and requires quick action on the part of the doctor. Allay the patient's anxiety by giving a sedative, but not enough to slow respiration. Spasm of the bronchial tube must be relieved. Loosen and help remove the thick mucous which is plugging the air passage. Adrenalin (1:1000) should be administered according to the age of the patient: large doses of antibiotics and chemotherapy should be given, and the patient placed in a warm steam tent. Often an emetic such as mustard will help the patient to cough out mucous plugs. The pulse should be recorded and stridor noted at least every 15 minutes. If the pulse increases 20 points in 15 to 30 minutes, or stridor increases, the patient should be hospitalized immediately and oxygen made available in the ambulance.

Epistaxis

When summoned to the home of a patient with epistaxis, he will most likely be found lying on a bed and utilizing a weird assortment of house remedies. Dispense with them and instruct the patient to sit up. Place a two inch piece of cotton, which has been saturated with an astringent, into the bleeding nostril and have the patient lean slightly forward. Pinch the nostril firmly with your fingers for about ten minutes. Have him maintain an upright position so that blood will not drain back into the throat. Local pressure plus an astringent will usually check the bleeding.

If the bleeding does not stop, the nose should be packed. When inserting a pack, the first portion should be placed as high in the vault of the nose as possible. The last portion of the pack should be placed along the floor of the nostril. Hemo-Pak is a half inch wide strip of hemostatic, absorbable, cellulose gauze which is easily handled and does not have to be removed until it becomes very loose from absorption after several days. It is an excellent agent for nasal packing. Penicillin in large daily doses seems to help control the bleeding, especially when packing has to be removed.

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SYMPOSIUM

REGIONAL ENTERITIS[1]

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It is a great privilege to address you this evening. It is a pleasure to be in Baltimore, the home of so much medicine, and the originator of so many medical ideas in the past. It is sort of ironical for me to be here at the moment because our Mount Sinai Hospital in New York City has in the last few years transformed itself to a full-time institution, and has at the head of four of its major departments, Johns Hopkins men: Guttmacher, Hodes, Gutman, and Ravitch.

[1] Presented before the Baltimore City Medical Society on Friday, January 15, 1954, at the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore 1, Maryland.

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It would be interesting to take a moment to go over the historical background and progress of the last twenty or thirty years of my lifetime on the subject of these inflammatory diseases of the small intestines. In my early days ulcerative colitis was a rare disease; today it is well-known. I don't suppose you can enter any ward of the Mount Sinai without seeing several cases of ulcerative colitis. In 1932 with Ginzberg and Oppenheimer, we introduced the concept of regional or terminal ileitis, in which the distal segment of 8 to 12 inches of terminal ileum was involved in an inflammatory granulomatosis process.

About 1930, the medical world became conscious of another disease which had been previously described but to which little attention had been paid, that is non-specific segmental colitis. This process involved the proximal colon, cecum, ascending and transverse colon but did not involve the sigmoid; it was essential that the sigmoidoscopy be negative. This non-specific right sided or segmental colitis was a different disease in many respects from the so-called "universal" colitis with which we were familiar. About 1936, we began to be conscious of the fact that not only could you have a terminal ileitis but we recognized the concept of ileojejunitis, a process involving the whole of the ileum and part or all of the jejunum. To the picture of terminal ileitis or regional ileitis was now added the concept of ileo-jejunitis. Subsequently it was learned that combined forms of these diseases did exist: regional ileitis, terminal ileitis, segmental colitis, and universal colitis.

In the last two or three years there has been a still further advance of this concept because now we recognize involvement of the duodenum. This has been seen in at least nine cases and probable involvement of the stomach in two instances. Recently I saw one of my most outstanding cases of terminal ileitis with a skip area in the first portion of the duodenum and involvement of the stomach as confirmed by gastroscopy.

Regional ileitis is not an uncommon disease; the fact that my statistics run to about six hundred cases, means that this is not a rare disease, even though I am unfortunately relegated to the role of specialist in regional ileitis.

My experience with ulcerative colitis probably covers more than two thousand to twenty-five hundred cases: the proportion is roughly five to one, five cases of ulcerative colitis to one of regional ileitis. Segmental colitis is still less common, the proportion would be about one to twenty cases of universal colitis.

Regional ileitis is a clear cut concept; a disease of young people. The average age is about twenty-five to twenty-seven years of age. It affects young adults; males somewhat more than females. The youngest case I have seen was nine months of age, confirmed by an exploratory laparotomy. The oldest case I remember was seventy-one years of age, though recently in the office we encountered a case in the late sixties and were interested to note that this case of regional ileitis apparently had its onset in the later decades of life.

As to etiology, that is a difficult question which cannot now be answered. The etiology of the disease is not known. It acts like a bacterial disease, particularly with its suppurative complications. It is obviously not bacterial in origin because nowadays it is so simple to sterilize the intestinal tract within forty-eight hours with modern antibiotics. A sterile stool culture will be reported back within forty-eight hours after the initiation of strict and ample antibiotic therapy, but the course of the disease in regional ileitis is not changed. I don't know whether Dr. Machella will agree with me, but after you similarly sterilize the colon in the case of ulcerative colitis you have not to any great extent altered the course of the disease although you may have improved the gravity of the suppurative complications.

One may hypothecate that there is a virus which is responsible for this disease; when asked about mixed cases of ileitis and ulcerative colitis,

one may conceive of ulcerative colitis as caused by one virus, of regional ileitis as probably a different type of virus and of the mixed cases as being infections with both viruses.

Why a virus? Because otherwise I cannot understand how successful surgical cases which are operated upon will remain well for long years and then return with recurrences of the disease. The longest recurrence I have seen has been nineteen years which is almost as long as I have known regional ileitis. I can conceive only of a virus type of disease which will lie dormant after a supposed successful operation and then break down and recur so many years later.

Certain facts about the etiology of ileitis are important. The familial incidence of this disease is quite in contrast to that of ulcerative colitis. Once only in my lifetime have I seen ulcerative colitis in more than one member of the same family. Regional ileitis is not uncommon in more than one member of a family, thus father and daughter, aunt and niece, brothers and sisters; in fact, in the first case of regional ileitis I ever saw, the sister several years later was also proven do be affected with regional ileitis. Both cases are alive and well today following successful surgery. The familial incidence is positive in regional ileitis and is completely absent in ulcerative colitis.

The factor of trauma is interesting. One does not often see trauma initiate a case of ulcerative colitis, but you can see trauma initiate a case of regional ileitis. The automobile today is an important factor in the etiology of regional ileitis, in accidents the body being thrown violently against the steering wheel.

The clinical appearance of regional ileitis when it is clearly defined and well marked is so definite that there should be no reason to mistake the diagnosis. A patient with a history of low-grade diarrhea; with a slight temperature; with a slight or progressive anemia, and with abdominal pain, the suspicion of regional ileitis should be entertained.

The negative sigmoidoscopy and the negative barium enema will rule out ulcerative colitis. Any case of diarrhea with abdominal pain, predefecatory in nature is suspect. This sequence of events recalls the rule of Moynihan with duodenal ulcer, namely: pain, food, relief, pain, food, relief. In regional ileitis, or in the inflammatory diseases of the small intestines, the sequence of symptoms is abdominal pain, defecation, relief; pain, defecation, relief.

The diarrhea in ileitis can be very mild; it is important to remember that a small percentage (5%) of cases of ileitis may have constipation. It is very embarrassing to overlook a case of ileitis because the patient was constipated and never had diarrhea.

The intensity of diarrhea in inflammatory diseases is in relationship to the proximity of the diseased focus to the anal sphincter. The nearer the inflammatory focus is to the anal sphincter, the greater is the diarrhea. Cases of ulcerative colitis, where only the rectum is involved, watched over the course of years rarely progress beyond the rectum; they are characterized by ten to twenty stools a day, with urgency and spasm, and with the passage of mucus and blood. In right-sided segmental colitis with involvement only of the right side of the colon the diarrhea is materially less with an average of six to eight stools a day.

When the terminal ileum only is involved, there may be three to four stools a day with abdominal pain. When the jejunum itself is involved, the diarrhea is still more ameliorated and less severe.

A progressive loss of weight is important in regional ileitis; anemia also is significant.

In differentiating the functional from the organic diarrheas, it is important that the patient take his temperature at eight o'clock every night and record it. Sooner or later the case of ulcerative colitis or of regional ileitis will demonstrate a slight rise of temperature and if the evening temperature is accurately noted a slight

rise of fever will differentiate the functional from the organic diarrheas.

The estimation of hemoglobin in the blood is essential in all such cases; the neurotic diarrheas, the irritable bowel, the mucous colitis, the allergic diarrheas, do not progress to secondary anemia. But the case of regional ileitis will sooner or later develop a secondary anemia of rather mild severity.

The psychic manifestations of regional ileitis are important to remember. Some of our cases come to us from psychiatric institutions where the diarrhea has just been taken for granted and interpreted as a neurogenic or psychiatric manifestation. Many cases are seen which have been institutionalized in psychiatric institutions for nervous diarrhea in which the x-ray examination of the gastro-intestinal tract has been postponed or deferred so long that the correct diagnosis has been overlooked.

Sooner or later the patient with regional ileitis is liable to develop a mass in the right lower quadrant of the abdomen, but the mass may also be located in the midline or even in the left lower quadrant. Where the terminal ileum is long and where the sigmoid forms a large redundant loop, fistulization may take place between the ileum and the sigmoid, so that the mass is pulled by the sigmoid over to the left side of the abdomen.

The outstanding characteristic of the disease, the one which is pathognomonic and which demarcates it, is the formation of internal and external fistulae.

The terminal ileum is the seat of origin of such fistulae. The colon does not produce fistulae to other organs except perirectal or ischio-rectal abscesses and fistulae; a fact which is common to all inflammatory diseases of the large and small bowel. The functional diarrheas never produce fistulae. No matter how long-standing a diarrhea is, one can differentiate the organic inflammatory diarrheas from the functional diarrheas by the presence or absence of a perirectal abscess or a perirectal fistula. These fistulae are characteristic of regional ileitis and do not occur in the functional nervous diarrheas or the diarrheas of ductless gland origin.

The terminal ileum represents to my mind a porous segment of the intestine. The ulceration, the granulomatous inflammation which originates in the submucosa, which goes on to invade the mucosa and causes secondary ulcerations, converts the terminal loop of ileum into a porous segment. The peptolytic enzymes of the intestinal content leak through the wall of the terminal ileum, follow the fascial planes and create fistulous tracks which travel far distances. These fistulous tracks may travel from terminal ileum to any other loop of small intestines; may travel from terminal ileum to large bowel, may follow the fascial planes and burrow and enter any hollow viscus. I have seen such fistulae perforate the body of the uterus. It is not unusual to see them perforate into the Fallopian tubes and give rise to salpingitis. They burrow into the urinary bladder, or into the posterior urethra in the male so that when the male urinates, he passes urine plus intestinal content and gas.

These fistulous tracks may burrow extensively and make their exit in the anterior abdominal wall in the scar of a previous abdominal incision, or even in the lumbar regions. They may terminate in the inguinal regions producing multiple fistulous tracks and openings in both of the inguinal regions.

The upper ileum rarely forms a fistula; the jejunum practically never originates a fistula.

Given the clinical picture of an abdominal mass plus diarrhea, an external fistula, fever, and secondary anemia, there is no excuse for not being able to make a clinical diagnosis or at least a provisional diagnosis of regional ileitis. Can the diagnosis always be made? Practically always, and either with or without radiographic confirmation. Some of the cases are so mild that they will continue for ten to twenty years with a mild diarrhea which is completely overlooked so that the diagnosis is not and cannot, be made.

Cases of acute regional ileitis are often violent with the onset of diarrhea and high fever, rigid belly and right lower quadrant abdominal tenderness; they simulate acute appendicitis. In between, you have all the variations from extreme severity of diarrhea and abdominal pain to the mildest type of manifestation in which the diagnosis can be overlooked for years.

I like to recall the case of a soldier who was in the Bataan death march, who undoubtedly had diarrhea when he entered the army, who survived the death march, survived concentration camp for many years and came in years later with a proven case of regional ileitis. In reviewing the history of diarrhea in his case it was almost positive that he had had regional ileitis during the entire period.

In another instance the patient had been a football player while in college, served through the war with the Marines, returned from service, and entered a professional football career; he had a most marked regional ileitis. I am sure that during that entire period he had regional ileitis. The markings in his intestines are so well defined and so sclerotic as to indicate an old and cicatrizing lesion.

Radiography is the final check on the diagnosis; when it is positive, it is conclusive. In about five per cent of the cases one can make a clinical diagnosis of regional ileitis, with negative radiographic findings. Often it has been my privilege to contradict the radiographer and to maintain the clinical diagnosis even though the radiographic films fail to demonstrate the disease. Fortunately in the largest percentage of cases radiographic confirmation is available.

The barium enema is the easiest way to pick up a lesion because in eighty per cent of the cases there is enough regurgitation through the ileo-cecal valve to demonstrate the terminal loops of ileum. Where it is not demonstrated by barium enema, a barium meal is indicated to study the small bowel. Radiography of the small intestine does not mean assigning the case to a technician and saying, take x-ray pictures on the third, sixth, and ninth hours and show me the films tomorrow. So many cases of regional ileitis can be missed by arbitrary setting times for the taking of films, that in many of the hospitals where technicians are assigned a good part of the work, the diagnosis is often overlooked.

It is most important to take the x-ray films at the time when the terminal ileum fills. My old radiographer "cussed me out" many a time for spoiling his dinner and social engagements at night because he would sit with the case and sit with it till the terminal ileum filled. He would then take that final film which showed the disease; many of the cases which I see, have been passed up by radiographers because they haven't used the proper technique. At times the Miller-Abbott tube, or the Levine tube is passed down into the small intestine and barium is injected as a small intestinal enema. In recent years we have discontinued that practice to a large extent.

The inflammatory disease which we recognize as regional ileitis begins at the ileo-cecal valve (I'm more inclined to use the term "begin" than "ends"). Actually I think it begins just proximal to the ileo-cecal valve where there is a normal physiological stasis of the column of chyme or chyle as it approaches the valve; at that point of physiological delay we have practically almost all the diseases of the small intestine, such as ileo-cecal tuberculosis, and nearly all the benign tumors, Sarcoid, Hodgkins, lymphosarcoma, carcinoid, etc.

The disease is characterized by thickening and inflammation of the intestine; by a rigidity of the wall; by a destruction and elimination of the mucous membrane pattern in this area, and by a reduction of the lumen. When the lumen is filled with barium and an x-ray picture is taken, the "string sign" will be seen. "This string sign," which was described by Dr. John Kantor, is characteristic and almost pathognomonic for this type of disease.

The distribution of the lesion in the majority

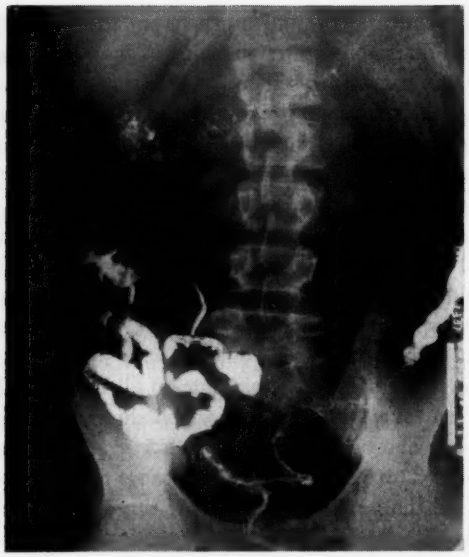

FIG. 1. Regional ileitis—string sign

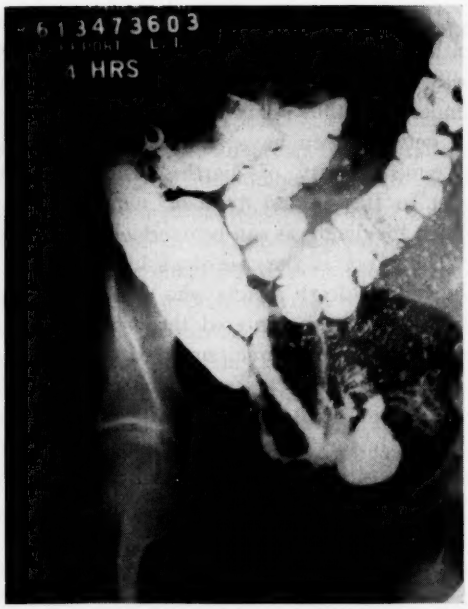

FIG. 2. "String sign" demonstrated by regurgitation of barium enema into the terminal ileum.

of cases is about twelve inches; ten, twelve or fifteen in most of the cases; eighteen, twenty-four inches is not at all unusual. Figure 1.

There are cases of regional ileitis particularly interesting to the surgeons because the manifestations so often begin with obstruction and in which only two, three or four inches of terminal ileum are involved. There also may be invasion all the way up; thirty-six inches, forty-eight inches, sixty inches or seven feet, which will carry you right up to the junction of the ileum with the jejunum.

Figure 2 is a characteristic picture of the "string sign" in the terminal ileum as demonstrated by regurgitation of a barium into the terminal ileum.

A diffuse ileojejunitis or an involvement higher up in the intestine makes it necessary to use the oral barium meal. With my experience in all the years I have been studying this disease, I have pulled a boner every once in a while by doing a barium enema, and forgetting to do a meal by mouth. It is rather humiliating to have your case return some time later with persistent symptoms, and to suddenly become conscious of the fact that you forgot to do a barium meal.

There are some cases where the upper jejunum or the jejunum and ileum above are involved and the terminal ileum is not involved, and those cases you will miss unless you do a meal by mouth.

Figure 3 demonstrates the "string sign" with involvement of the entire ileum in a patient who had psychotherapy for eight years. This man came down from an institution where it had been taken for granted that he had a nervous diarrhea; the psychiatric manifestations were so predominant that the diarrhea was overlooked. You can imagine the astonishment of all of us when a routine G. I. x-ray series was taken to discover the involvement of the whole ileum.

A physician, who had been serving in a psychiatric institution in New York State for many years, had been joshed by his comrades because of his diarrhea. It never dawned upon any of

the doctors to take a gastro-intestinal x-ray in this psychiatric institution. He was the most surprised man to discover that he had regional ileitis.

Late in the disease one sees polypoid and cicatrical changes. I haven't said much about obstruction because obstruction is rare and takes place late in the course of the disease.

There is in addition to the cicatrizing, localized form of regional ileitis, a mucosal form, a rapidly spreading mucosal form which is very disturbing to us because it is the type of case that lends itself so badly to successful surgery. This type of case should interest the surgeons as well as the medical men because these are the cases that you like to leave alone.

The mucosal type of regional ileitis with rapid spread, is a very disastrous type to study. The clinical progress is fast and rapid, the downward course is extreme. When we talk about surgical treatment, you will see that in recent years this type of case has warned us away and made us restrict ourselves to sclerosing cicatrical types where the upper end of the lesion can be well defined.

Perirectal fistulae usually occur as complications of infection of the crypts of Morgagni. The infection—if it be an infection—is brought down with the fecal column, rests in the rectum and infects the crypts, giving rise to an ischiorectal abscess or ruptures internally to the rectum and externally to the buttocks giving rise to a perirectal fistula. There are some cases in which the fistulization begins above in the ileum; in which lipiodol injection of the fistulous tract will allow you to follow this fistula all the way up from the rectum right to its base in the terminal ileum.

These fistulas are very interesting, since, if you short-circuit the lesion or resect the lesion, the fistula dries up.

Recto-vaginal fistula is another characteristic of this disease, though not necessarily pathognomonic for regional ileitis because it can occur and

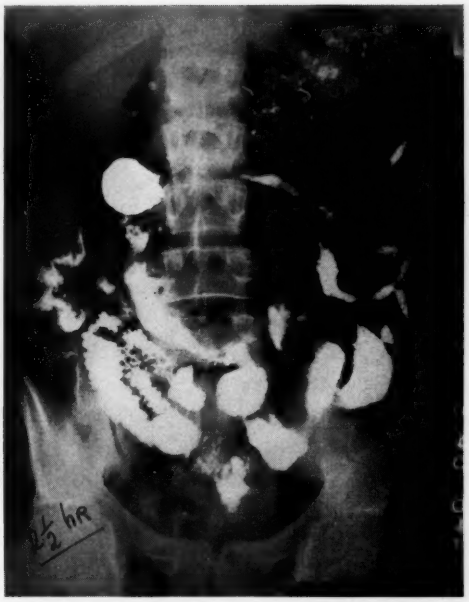

FIG. 3. Involvement of the entire ileum in a patient treated from the psychiatric viewpoint for eight years.

does occur with ulcerative colitis, and as a common complication to pregnancy and delivery in cases of ulcerative colitis. If you insert your finger into the rectum in ulcerative colitis and bend your finger forward, you will find the oldest ulceration in the rectum. It is that anterior ulceration which breaks through the septum between the vagina and the rectum and gives rise to the recto-vaginal fistula. These fistulae are most difficult to cure by surgical means.

Ileitis and ileojejunitis are characterized by low-grade temperature. Figure 4. The general internist must bear in mind that low-grade temperature with joint involvement and with eye manifestations is characteristic of both ulcerative colitis and of ileitis.

The joint involvement and eye manifestations are more common to ulcerative colitis than they are to ileitis; such low-grade temperature is often mistaken for rheumatic fever or periarteritis nodosa, or lupus erythematosus disseminatus, or any of the diseases which are

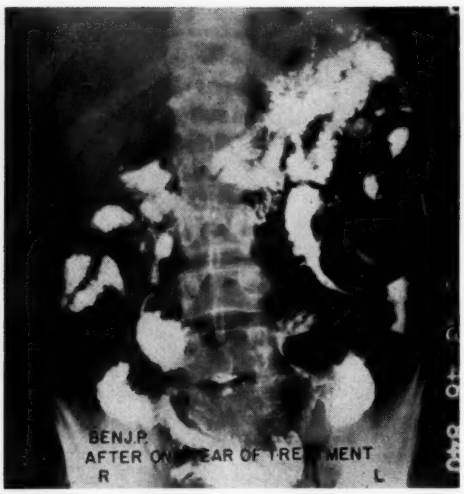

FIG. 4. Ileitis and ileo-jejunitis

accompanied by low-grade temperature and low leukocyte counts.

Any low-grade temperature with low leukocyte count, with continuous fever of unknown origin should always be suspected of possibly being due to regional ileitis or a right-sided or a segmental colitis. I have been in this city twice to see cases of this type. One was explored at Johns Hopkins by Dr. Firor, some years ago, but nothing surgically could be accomplished because of the widespread extent of the disease. The other was a case which had continuous fever with joint manifestations and in which the discovery of perirectal fistula cleared up the diagnosis.

Incidentally, one rarely sees a death in regional ileitis; one practically never sees an autopsy. The acute fulminating regional ileitis cases are best left alone. If anybody is brash enough to operate upon them and attempt a resection a high mortality rate is invited.

The terminal ileum rarely heals itself. The upper ileum and jejunum are capable of self-healing in a large percentage of the cases. This constitutes an important therapeutic difference because terminal ileitis if not able to heal itself is amenable to surgical treatment, while the upper small intestine which is not amenable to surgical treatment has the capacity and the faculty of healing itself under favorable conditions.

With the involvement of the upper ileum and jejunum, nutritional changes occur which remind one a great deal of sprue. The two diseases cannot be confused in any respect. It should not be difficult to differentiate sprue from ileojejunitis, because the roentgenographic picture of sprue is so definite. The radiographic picture of ileojejunitis is also characteristic. Both diseases are characterized by enlargement of the spleen, by a primary type of anemia, by clubbing of the fingers and by nutritional disturbances due to impaired absorption of electrolytes and nutriments. So-much-so that in diffuse ileojejunitis, one often sees a hyperchromic type of anemia; one also sees tetany, salt-deprivation, and potassium changes that are really clinically significant. Nutritional disturbances and loss of weight are most characteristic of diffuse ileojejunitis.

I don't think that the present-day surgeon would attempt the sort of surgery which was undertaken in the early days before we learned that the upper jejunum is capable of healing itself.

We are now beginning to be conscious of the fact that there is a type of pure jejunitis with involvement only of the upper jejunum, as described in Germany. We have seen few of these cases; we have many records of localized resections of the upper jejunum; and are beginning to be more cognizant of this type of the disease, as we also recognize involvement of the duodenum. The Mayo group published five cases with involvement of the duodenum some years ago. Our staff at the hospital are about to report five more cases with involvement of the fourth portion and the third portion of the duodenum. Usually there is obstruction, with vomiting. The picture of post-pyloric obstruction is very characteristic of ileojejunitis with involvement of the duodenum. The operative cure of such a

complication is very difficult to undertake. It can only be accomplished by anastomosis or some form of gastroduodenostomy or duodenojejunostomy with transection of the duodenum if it is possible above the lesion.

I believe that I have seen stomach involvement in three cases. A recent publication from England, cited two proven cases of ileojejunitis involving the stomach. This morning, I saw the gastroscopy for the second time on a case of ileojejunitis or ileitis with involvement of the stomach.

There are mixed forms of ileitis and colitis. I am sure Dr. Machella will take up this topic. Dr. Machella will probably describe to you the seriousness of ulcerative colitis which is a much more severe and serious disease than ileitis or ileojejunitis; when one meets the combination of ileitis with ulcerative colitis, two of the most serious diseases are then combined and superimposed one upon the other.

In the few minutes which I have left, I'd like to talk about the therapy of regional ileitis. As far as the differential diagnosis is concerned, there are other diseases that affect the terminal ileum which must be differentiated from regional ileitis.

I have been very confounded by lymphosarcoma of the terminal ileum which may be diagnosed mistakenly as terminal ileitis. The clinical picture may be typical of ileitis without fistulization, but characterized with a progressive downhill course and "string-sign" in the radiographic films.

Carcinoid of the terminal ileum can produce the clinical picture and the radiographic "string signs" of terminal ileitis so much so that differentiation is impossible without resection. Abdominal Hodgkin's disease with multicentric involvement of the lymph tissue throughout the intestinal tract can give a clinical picture very much like regional ileitis; very confusing; the clinical course is, however, much more severe and more rapidly fatal.

Endometriosis with implantation upon the terminal ileum confused me once and led me to a diagnosis of regional ileitis in a woman of which the diagnosis was finally clarified. But in general all of these diseases are extremely rare. They are our fanciful rarities in medicine; regional ileitis is the common disease.

Is there a medical treatment for regional ileitis and what is the prognosis? In my three hundred odd cases which I followed up and published in 1947, I think I quoted about twelve cases of spontaneous cures. If these twelve cases had been followed longer, I'm not sure they would have remained cured, or whether they would not have broken down with recurrences after a length of time.

The medical treatment of regional ileitis today rests upon supportive low roughage diet; nutrition is very essential. The blood proteins must be studied, the albumin globulin ratio must be noted; the calcium content and sodium content of the blood must be seen. Transfusions are essential. Vitamin replacement is important. The use of the newer antibiotics is recommended if not for the disease at least for its complications. Sulphathaladin is used almost to the exclusion of all the other sulpha drugs. I have tried azopyrin, sulfasuxidine, and some of the newer sulpha drugs, but the most effective to my mind is sulphathaladin which can be prescribed over weeks and months without worrying about agranulocytosis or hepatitis, because of the lack of absorption of these insoluble sulfa derivatives.

Of the other antibiotics, penicillin is useless in the intestinal tract for any of these inflammatory diseases except perforation with peritonitis. I have yet to prescribe my first capsule of aureomycin or terramycin because I know that both aureomycin and terramycin are capable in themselves of producing diarrhea with changes in the intestinal flora with overgrowth of monilia or staphylococcus aureus. These are capable of giving rise to a new type of diarrhea which may be almost as severe as the original disease. My old standbys are streptomycin and

chloromycetin; chloromycetin is one of the most powerful and successful of intestinal antibiotics in spite of the fact that agranulocytosis may occasionally be produced.

The interest, of course, to date centers upon two other aspects of therapy. Is this a psychosomatic disease? and the use of ACTH and Cortisone. In my opinion ileitis is not a psychosomatic disease. If I am pinned down for a definite answer, yes or no, I would say that ulcerative colitis is definitely a psychosomatic disease subject to every psychic influence. I am now convinced that psychic trauma can originate ulcerative colitis a fact which I wouldn't have conceded a couple of years ago. As for the course of ulcerative colitis, the psychic factors are important throughout and the cure of the patient depends to a large extent on the rapport of the physician with the patient and his treatment of the psychic state of mind.

But in regional ileitis the psychic factors are relatively unimportant. ACTH and Cortisone are currently used in the treatment of regional ileitis and ileojejunitis, because in ileitis and ileojejunitis just as with ulcerative colitis, the beneficial effects are so immediate and so prompt, the improvement of the appetite, the euphoria, the general well-being are so important that the patient is much benefitted by ACTH which can then be followed by Cortisone or hydrocortone by mouth.

A recent patient had been taking twenty-five milligrams of Cortisone uninterruptedly for a year without bad effects. As far as the dosage of the ACTH is concerned, as I travel over the country I am more and more amazed at dosages. I find myself extremely timid in my dosage and possibly very insufficient in recommending adequate dosage.

Some institutions have been using up to a hundred to two hundred milligrams of ACTH intramuscularly for the treatment of ileojejunitis, with benefit; as in sprue hydrocortone seems more efficient than Cortisone when given by mouth.

Surgically, we still tend to short-circuiting rather than resections. We deplore the fact that we have twenty-five per cent or more of recurrences which recurrences can occur as late as nineteen years, after the original operation. Surgery is adaptable to terminal ileitis, particularly when it is in the cicatrized or rigid sclerotic segment with an upper limit which can be well defined at the operating table. Even with twenty-five per cent of recurrences, surgery is well indicated as a cure for regional ileitis particularly in the presence of fistulous complications, the appearance of an abdominal mass, or the presence of obstruction.

Recurrences proximal to the site of intestinal anastomosis are best managed in a conservative manner. Reoperation and further short-circuitive procedures may lead to higher recurrences until both much of the utilizable small intestine and its function in maintaining nutritive balance have been sacrificed.

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CHRONIC IDIOPATHIC ULCERATIVE COLITIS

Problems in Etiology and Management

THOMAS E. MACHELLA, M.D.*

Etiology

Among the major hypotheses advanced to account for the development of ulcerative colitis are; infection, deficiency of a specific intestinal factor, excessive lysozyme production, damage to the colon by proteolytic enzymes of the upper gastro-intestinal tract, allergy, and emotional factors.

1. *Infection?*

The clinical picture of ulcerative colitis so frequently characterized by diarrhea and fever as well as the pathological appearance of the colon have strongly suggested an infectious etiology. It was natural, therefore, that attempts be made to isolate a specific organism, and indeed a variety of bacterial as well as other organisms had been incriminated.

The two which have stimulated the greatest amount of interest have been: The dysentery organisms and the gram positive diplococcus. I won't go into the evidence suggesting that these organisms are important in the etiology, but I will give you some of the points against the contention that the disease is caused by either of the two organisms.

As far as the dysentery organisms are concerned, there has been a failure to isolate dysentery organisms in large series of cases by several different groups of workers. Furthermore, there is a lack of infectiousness of the disease. It is rare to find more than one case of ulcerative colitis in the family and it is still more rare to find more than one case occurring in the family simultaneously. Finally, the finding of only one case of ulcerative colitis in a sixteen year follow-up of 102 cases of bacillary dysentery by Brown and Bargen speaks for itself.

As far as the evidence against the diplococcus is concerned, it consists mainly in the fact that it has been possible to isolate the organism from the feces of patients with a variety of intestinal diseases and this has led to the conclusion that the organism is a secondary invader.

The evidence against ulcerative colitis being due to a specific bacterial agent at all is as follows: 1) There has been a failure to isolate a pathogenic organism uniformly and, 2) the percentage of patients who improve while antibacterial agents are administered is about the same as from some measures not aimed primarily at treating infection. A summary of the reported results of various sulfonamides reveals that improvement was attributed to them in 57.7% of 1,275 cases. A similar survey of the results ascribed to antibiotics reveals improvement in 61.6 per cent of 167 cases. There have been far fewer reports on the results of treatment with antibiotics than with sulfonamides.

My own experience with these agents has been disappointing. The disease has its variations in severity and duration, and when I have used these compounds in really stubborn cases, no detectable favorable effect on the clinical course of the disease has been produced. For example, sulfasuxidine, penicillin, and streptomycin have been administered at different times to a specific patient with no effect on the diarrhea or on the fever over a period of some 40 days. Finally, the patient was given large doses of aspirin because he had joint manifestations, and everything quieted down very nicely. On the other hand, another patient was brought to the hospital with fever and diarrhea. She received no treatment whatsoever except reassurance and the security

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of the hospital. Her temperature and diarrhea subsided very nicely. It could be very easily said that if extract of watermelon seed, or a sulfonamide, or whatnot, were administered at that time, that agent might have been credited with causing a subsidence of symptoms.

Problem of Depression of Bacterial Flora of Colon. The role of bacterial flora of the colon in the maintenance and accentuation of the disease is very difficult to assess. This much can be said:

1) There is a lack of correlation between changes in the fecal flora brought about by the various antibacterial agents and the clinical course of the disease.

2) Careful studies by Marshall and his associates, at the University of Chicago, have revealed that although the fecal flora can be altered temporarily by the sulfonamides, after a while, the flora resembles that of the untreated patient in type and quantity.

3) A fecal flora resistant to antibiotics develops more or less rapidly after continued administration of the compounds.

4) The use of these agents may be deleterious. Side-effects including diarrhea and fever, on the basis of ulcerations in the colon not previously present, can result from their use. I have seen such occur and it has been reported in the literature. I, personally, do not use antibiotics or chemotherapeutic agents in ulcerative colitis unless suppurative complications threaten or exist.

2. *Ulcerative Colitis—a Deficiency Disease?*

The possibility that ulcerative colitis may be a deficiency disease and that the responsible factor is lacking from the intestinal tract was proposed by Gill in 1945 on the basis of favorable results obtained when preparations of hogs intestinal tract were administered.

The results of therapy with various preparations of various portions of the hogs intestinal tract have, in general, been disappointing. Good results have been reported in anywhere from 52 to 81 per cent of 104 cases, depending on the criteria used in judging effectiveness of treatment. My own experience with a preparation of hog's duodenum in a small number of intractable cases has been unsatisfactory. In fact the preparation appeared to cause a great deal of flatulence and some of the patients refused to continue taking it.

3. *Ulcerative Colitis Due to Excess Lysozyme Production?*

The finding of an increased concentration of lysozyme in the stools of patients with ulcerative colitis, led Meyer and his associates to suggest that lysozyme is of etiologic importance in the disease. There can be little doubt that an increased amount of lysozyme is found in the stools of ulcerative colitis patients during activity of the disease. This finding has been confirmed in more than one laboratory.

It was postulated that lysozyme removed the protective surface mucus from the colon by virtue of its mucolytic activity and this favored ulceration of the denuded mucosa by indigenous bacterial flora.

The evidence against the lysozyme hypothesis is as follows:

1) The original work on animals whereby ulcerations were produced by the instillation of lysozyme into the colon of dogs has not been confirmed.

2) It has been found that lysozyme in large amounts is present in granulation tissue and that pus cells and bacteria can produce lysozyme.

3) An inability of some workers, such as Glass and his associates, to demonstrate any mucolytic activity of lysozyme in vitro on colonic mucus.

4) There has been a lack of correlation between fecal lysozyme titres and the clinical course of the disease when antilysozyme agents were effective in depressing fecal lysozyme titres.

5) There also has been a lack of a spectacular benefit from the administration of antilysozyme agents. Good results have been reported in 66.1 per cent of 121 cases treated with various antilysozyme agents.

4. *Ulcerative Colitis and Pancreatic Enzymes*

Dr. Portis suggested that pancreatic enzymes might be of importance in the etiology of ulcerative colitis. He based his concept on the basis of damage to the colonic mucosa of dogs following the instillation of 2 per cent trypsin.

The evidence against this hypothesis is as follows:

1) The occurrence of ulcerative colitis in individuals with a proven deficiency of the external secretion of the pancreas as a result of chronic pancreatic disease.

2) The recurrence of activity in the colon following ileostomy, i.e., even though the small intestinal content is diverted from the colon and pancreatic enzymes have no chance to get into the colon.

5. *Allergy*

The etiologic role of allergy in ulcerative colitis was proposed by Dr. Andresen and stressed by Dr. Rowe. The reason for their concept has been that they obtained favorable results when food allergy was taken into consideration in the management of the disease. Dr. Andresen, for example, felt that allergy was responsible in 66% of his cases, while Dr. Bassler thought that allergy was significant in about twenty per cent of his. Drs. Collins and Pritchett, after careful study of their cases, failed to find that food allergy was a common cause of the disease, but found that allergic management was helpful.

To me the situation in regards to allergy seems to be as follows: 1) Food allergy has not been established as a cause of ulcerative colitis and, 2) food allergy should be looked for in every case of ulcerative colitis and when present, should be taken into consideration in the management of the patient.

6. *Role of Emotional Factors*

The role of the psyche in the etiology of ulcerative colitis was emphasized as far back as 1930 by Dr. Murray, but not much attention was paid to this aspect of the disease until recently. The reason for this has been, not only the influence of those who believed in a bacterial etiology, but the enthusiasm aroused by the first reports of each of the chemotherapeutic agents, as they were discovered. However, as the early enthusiasm attending the use of these agents was replaced by disappointment, increasing attention has been paid to the role of emotional factors.

Characteristic personality traits in the patients have been uncovered as well as evidence of unsatisfactory relationships between the patient and one of the parents. Impressive relationships between emotional stress and the onset of the disease and the occurrence of relapses, have been uncovered by individuals who take enough time to look for them. Furthermore, the results of psychotherapy, skillfully administered, have been better than from many other regimens. The results of psychotherapy, poorly administered, as one would expect, have been unsatisfactory and at times harmful. Many of the patients can be handled by the internist acting as his own psychiatrist, particularly if his personality is such that he can instill confidence and arouse hope in a patient who has been subjected to a variety of emotional frustrations and insults. Occasionally, expert aid from a trained psychiatrist may be necessary.

A summation of the results of miscellaneous therapy reveals a tremendous variety of therapeutic measures employed, each with satisfaction to its advocate. Adrenal cortical extract, arsenic, benadryl, chlorophyl, intragastric drip, medical ileostomy, propylthiouracil, testosterone, vagotomy, vitamin B_{12}, etc. The results from each are claimed to be good. How can good results from such a wide variety of therapeutic regimens be explained? To me, it simply indicates that the disease responded to the psychotherapeutic value of the program used. After all, the simplest form of psychotherapy is reassurance and such reassurance is supplied the ulcerative colitis

patient when he sees any doctor who makes a good impression on him and in whom the patient has faith and confidence. If at the same time, a new remedy is prescribed in a convincing manner, the chances are two or three to one that the symptoms will remit temporarily. Such a situation, I feel certain, accounts for the 60 to 70 per cent, or even higher, of the good results from most of the regimens used.

Analysis of records will reveal cases in which correction of patient's problems resulted in remissions which have lasted up to 8 and 9 years.

For example a patient with symptoms while under considerable stress as a result of his wife's dying of carcinomatosis had a disappearance of symptoms after her death. The patient remarried and has been in complete remission for nine years.

Another patient's emotional problem revolved around a desire not to have further pregnancies. Barium enema revealed a badly diseased colon. With the full cooperation of her husband, the fear of future pregnancies was removed and she lost her symptoms. Thirty-two months later, still asymptomatic, the colon looked as if it had never been diseased to the extent indicated earlier. She has been in remission for eight years and has survived a cholecystectomy and a myocardial infarction without a relapse in symptoms of ulcerative colitis.

A rather badly "chewed-up" colon was revealed by barium enema in a little boy, aged thirteen, who had a problem. He weighed forty-eight pounds, had bed sores and contractures of the knees, and was desperately ill. He had involvement of not only his colon but also of his small intestine. Surgery was considered but was turned down by the surgeon because of the critical condition of the patient and the extent of involvement of the small intestine. We tumbled on to what his problem was, and handled it to his satisfaction. It was resolved by prescribing psychiatric treatment for the boy's mother. He began to improve and went into complete remission in which he has remained for the last 8 years. At present he weighs some 180 lbs. He has been in remission eight years, and his colon appears entirely normal on barium enema examination.

A 41 year old housewife and mother of 3 children, came to see me while on her way to another city to see a doctor who was supposed to be having success with a new antibiotic. She had had a trial of the older ones without benefit. I told her that I didn't think antibiotics would supply the solution of her problem, and that I thought that she was very unhappy about something. She broke out into tears and admitted that she was very, very unhappy. She also stated that diet was not important because when she was on vacation with her husband she ate anything she wished, including cabbage, and felt well. However, when she returned home, took antibiotics and adhered to a low residue diet, the colitis became active again.

Well, this was exactly what I was looking for. I learned that her husband, an ambitious attorney, wan't spending very much time at home. He was a good man, had built her a large new home, but had to work hard to enlarge his law practice so that he could pay off the mortgage. The patient's mother and father, who lived with them, criticized him constantly for being away so much; this didn't help. She felt that these factors were responsible for her unhappiness. I agreed and suggested that her mother and father move into other quarters. She thought this could be accomplished readily. I also said I wanted to talk to her husband. I felt I would be able to get him to see that he could pay for the new home much earlier if he spent more time in it and didn't have to pay for expensive antibiotics, transfusions, hospitalizations, etc. which her illness during the past 7 years had necessitated. She brought him along on the next visit and I told him the facts as I saw them. He replied "if you think that I'm doing this to my wife, it stops as of now; tomorrow we leave on vacation" and they did. The

parents moved into an apartment nearby. She has had no symptoms of ulcerative colitis since that time, some 4 years ago. It took only two hours to discover the trouble and correct it. Not all of my cases of ulcerative colitis are as easily managed as this one was.

ACTH and Cortisone

Factors underlying the basis for the use of ACTH or cortisone in the treatment of ulcerative colitis have been the occasional occurrence of erythema nodosum and arthritis as complications, as well as the finding of low values for urinary ketosteroid excretion.

Cortisone therapy may produce a rapid subsidence of fever, a gain in weight with a return of appetite and a restoration of the erythrocyte sedimentation rate to normal. Diarrhea ceases promptly or subsides gradually. Erythema nodosum and arthritis rapidly disappear. Roentgen and sigmoidoscopic evidence of healing lags behind clinical improvement and is seen only if the remission induced lasts a long time.

The type of patients who appear to respond best to ACTH or cortisone are: 1) those with the acute fulminating disease, 2) badly debilitated individuals, 3) those whose total circulating eosinophiles are low and, 4) those with erythema nodosum and arthritis.

These agents do not cure the disease any more than insulin cures diabetes. Emotional factors should be searched for and handled after the patient begins improving. The dosage should be gradually reduced to maintenance levels and then further reduction made slowly (at weekly intervals) until none is being administered in order to give the adrenals a chance to become restored. This should be done to avoid a dependence on the compound, which in the case of cortisone can be almost as bad as addiction. When tapering off the dosage of cortisone it is sometimes well to administer ACTH concurrently. When using these agents one must keep in mind that infection may be masked; because, they in addition to having an antipyretic action, lessen toxemia, and thus remove valuable signs of serious infection.

It has been suggested by several individuals that perforation of the colon occurs more frequently in those ulcerative colitis patients who are on these compounds. I don't see how the point can be proven. Ulcerative colitis is a disease in which perforation is a well recognized complication. How is one going to tell whether or not cortisone or ACTH administration increases the susceptibility to perforation except by comparing large series of cases. If perforation never or rarely occurred in ulcerative colitis and then occurred frequently after cortisone was administered, I'd be willing to attribute the increased incidence to cortisone. I have gone over our own cases. In about 100 patients who did not have cortisone, there were 7 who perforated; in 20 treated with cortisone, one perforated. I have recently learned from a colleague who just returned from England of a series of 100 cases treated with hormones and another comparable number treated by other measures. There were 3 or 4 perforations in the group who did not receive the hormones as against none in the group that did.

A patient with evidence of extensive involvement of the colon on barium enema as well as the small intestine, had at least five perforations in the colon as indicated by the escape of barium outside the confines of the colon. The surgeons were inclined not to operate on the patient because they felt she was in too critical a condition. The patient was placed on cortisone and made an excellent recovery. She now attends our clinic as an out-patient. She has gained considerable weight and can do her own house work. As a matter of fact, she has succeeded in marrying off her divorced daughter quite happily and I predict no recurrence unless the daughter's second marriage is unsuccessful.

Our policy, as far as these compounds is concerned, is not to use them unless nothing else works and the situation is desperate. We have used them in cases with perforation, mas-

sive bleeding and with massive edema as a measure of desperation with very satisfactory results.

Carcinoma and Ulcerative Colitis

The problem of carcinoma and ulcerative colitis is a serious one because if the disease predisposes to an alarmingly high incidence of colonic malignancy, then perhaps prolonged efforts at medical management in certain instances should be avoided and the colon removed. The literature up to 1944 was reviewed by Lynn. He found that the incidence of colonic carcinoma was 1.9 per cent of 1,467 cases. I have reviewed the literature since 1944, and have found the incidence of cancer is 3 per cent in 6,890 patients. These figures have not been corrected for the natural incidence of carcinoma of the colon and rectum which ranks fairly high as a cause of death in adults.

A 3 per cent incidence of carcinoma of the colon in ulcerative colitis must, of course, be taken into consideration in the management of patients with the disease, but it should not provide an occasion for hysteria on the part of the physician. Such an incidence is less than the mortality of colectomy in several clinics. What is more impressive than the incidence of carcinoma in ulcerative colitis, is the age of ulcerative colitis patients who get carcinoma. In Dr. Sloan's 2000 cases at the Mayo Clinic, the incidence of cancer of the colon was 5.4 per cent. The mean age was forty-two years. The greatest number occurred between the ages of thirty and thirty-nine years. The youngest was fifteen at the time of death.

Opinions of many are in agreement on some of the points in the problem. In the first place, most individuals agree that carcinoma appears to develop more readily in the colons of those who have had the disease a long time. Secondly, the carcinoma which develops is highly malignant and metastasizes early and thirdly, it may develop in more than one site. Most writers on the subject are not impressed with the tendency of pseudopolyps to undergo malignant change. I, personally, am considerably scared of pseudopolyposis, particularly in the patient who continues to have low-grade activity of his colitis. I do not hesitate to recommend colectomy in such cases. I am less afraid in the patient who is doing very well and is in remission. I have seen roentgen evidence of pseudopolyposis disappear in such cases.

Surgery for the Intractable Case

Surgical intervention in the patient with intractable symptoms is an individual problem and each case should be decided on its own merits. The surgeons complain, and frequently with justification, that medical men permit patients to go down hill too far before they ask for help. They, therefore, operate on bad risks, and have a high mortality. On the other hand, there is no doubt in my mind that some patients have been committed to an ileostomy life unnecessarily, because remissions can and do occur even after months of treatment in apparently hopeless situations. My own policy is to recommend surgery when the emotional problems motivating the disease cannot be handled and the outlook is hopeless.

As you all know, a small intestinal involvement may occur in association with ulcerative colitis. An ileostomy performed through diseased ileum predisposes to fistula formation, abscess, and these mean a prolonged convalescence. The small gut should be X-rayed in every patient with ulcerative colitis as soon as practical and again before surgery, if a long interval has elapsed between the initial small intestinal X-ray and time of surgery. Involvement of the small gut may be more evident in the subsequent examination and be so extensive as to contraindicate surgery, in which case one may have to resort to cortisone or ACTH.

In summary, problems of etiology and management have been discussed. It is important that treatment should be individualized. Supportive therapy consists of the correction of existing deficiencies; i.e., transfusions and iron for anemia, prompt correction of electrolyte

imbalance including potassium deficiency, and dehydration, and the administration of vitamins and a nutritious diet rich in protein. Emotional problems should be tactfully searched for and solved. This requires, very frequently, time and patience on the part of the physician. ACTH and cortisone may prove to be life saving in cases that defy ordinary conservative measures. The use of these agents should be discontinued after the dosage has been gradually reduced over a period of weeks or months. Surgery should be resorted to in those cases in which a remission can't be induced by other means.

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QUESTION AND ANSWER PERIOD

DR. GUNDRY: I want to thank Dr. Crohn and Dr. Machella for their most interesting presentation. Their talks are open for discussion or for questions from the floor. Does anyone want to comment or ask questions?

Q. DR. HOWARD: I'd like to ask Dr. Crohn if he feels that one operation for terminal ileitis is all the patient should have? It has been my feeling that if one has an operation for terminal ileitis and has a recurrence two or three years later, that I'd like him to have a second crack at a cure because if he doesn't have that second crack, he probably would be inclemented by it for the rest of his days.

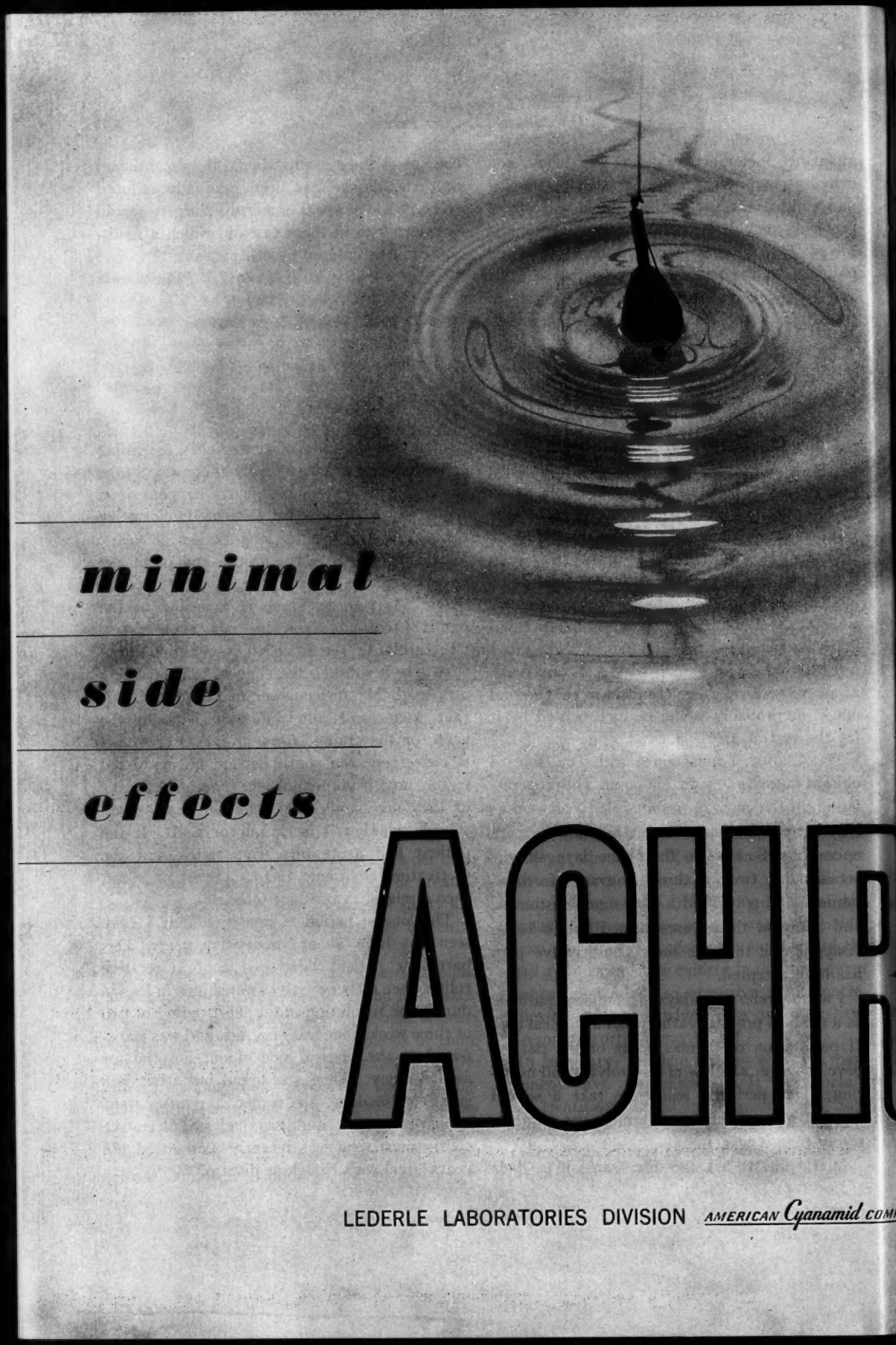
DR. CROHN: I must agree with Dr. Howard on that question to a certain point. The reoperating of all the cases of terminal ileitis as soon as they recur led to more recurrence and to more operations. So that in the olden days we saw occasionally two or three ileotransversecolostomies ending up with ileo-sigmoidostomies, and many of those cases turned out to be so disappointing that the more conservative plan has been accepted.

I would prefer nowadays to handle my patients as a medical problem rather than a surgical one. If perforation or fistulas occur or the patient develops fever and loss of electrolytes and nutrition, I am perfectly willing to take a second try, but my attitude is much more conservative today than it was.

Q. I'd like to ask the discussants if in their opinion in most cases of acute ileitis, ulcerative colitis, cure themselves or are there any statistics to show for instance what happens to a large series of medically treated ulcerative colitis patients over a long period of years. What happens to them at the end of ten or twenty years?

DR. MACHELLA: There is a feeling in the minds of some clinicians concerning acute ulcerative colitis, or the so-called fulminating form, that once it subsides the chances of it recurring are small. My own answer to this question is that there isn't any difference between the acute or the chronic form as far as prognosis is concerned; that both depend on emotional factors, and if you handle the emotional factors or they are handled for you, the disease will subside whether it is chronic or acute. If the patient had acute ulcerative colitis and the motivating emotional factors persist or recur, then a relapse is very apt to occur.

The longest period of remission that I have seen has been about twenty-five years. This particular patient developed acute ulcerative colitis when all her relatives were killed in Russia during the revolution in the short period of two or three weeks. She was very sick and was transferred to the surgical side of our hospital for an ileostomy. When she found out what was going to be done, she signed a release, went home, improved, and has had no ulcerative colitis since. She was recently readmitted (25 years later) with Hodgkins disease.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Q. Does vagotomy have any role in the therapy of regional enteritis?

DR. CROHN: Twice I have seen vagotomy used for a diffuse regional ileojejunitis; the results were sad. I only wish, Mr. Chairman, I could develop as much enthusiasm for psychotherapy as Dr. Machella. He makes it very simple. First of all, I'd like to ask Dr. Machella how often, and whether he has seen some of the very disastrous and sad results of attempts to treat with psychotherapy, patients running 104 temperature and so toxic that they can't eat. My experiences with that type of attempted psychotherapy in the critical period, has not been good. I'm very glad Dr. Machella gives the impression that he is his own psychotherapist which I think is the important role that all of us have to play when we treat cases of ulcerative colitis or regional ileitis. Remember, you've got to be around the individual and you have to know a great deal of life; you have to understand child psychology, and be able to understand the problems of the individual. It is not as simple in practice as Dr. Machella makes it.

On the subject of carcinoma—I know that Dr. Machella has seen the recent literature, for the incidence of carcinoma in ulcerative colitis with figures of controlled incidence of carcinoma in the general population. I am pretty well convinced the incidence of carcinoma of the colon is higher in ulcerative colitis than it is in the native population as a control. Also that most of these carcinomas take place in the rectum. Also that they occur after twelve or more years of prolonged ulcerative colitis. Also the fact their most significant factor is early metastasis to distal organs. In the series of thirteen cases seen by Dr. John H. Garlock only one case has survived after ten years.

DR. MACHELLA: The difficulty with psychotherapy is that it is time-consuming. One has to drop whatever he is doing when the patient is in trouble and help him out. Unless one is willing to do that, one might as well not try it. Actually, it takes patience, common sense, a sympathetic attitude, and, above all, a lot of time.

I agree that it would be foolhardy to turn a patient who is sick with a fulminating colitis over to a psychiatrist. Such a patient shouldn't even have a barium enema or proctoscopy.

I have seen cases turned over to psychiatrists not familiar with the disease. I know of at least two patients who committed suicide after the first interview. A third patient, a young man who after the first hour with a psychiatrist, returned to his hospital room, put on his street clothes, and disappeared. He has not been seen or heard of since.

I have referred patients to the psychiatrist when I felt I wasn't getting anywhere; I was not able to handle the situation myself and needed expert help. I have referred him about five or six that I recall offhand. In all of these except one, the patient has come back to me. We now have two cases of ulcerative colitis that have been referred to us by psychiatrists. We are still struggling with one of them, and the other is in remission.

I ask the patients that I have sent to the psychiatrist and who come back and say they don't want to go back to him anymore, why don't you want to go back. "Well, he just sits there and writes, he never says anything, doesn't do anything for me, just writes things down." He doesn't let them lean on him like I do. The psychiatrist is pretty objective and has to be. I think the psychiatrists who have allowed the patient to "transfer" to them have had the best results.

I also feel that regional enteritis is a psychosomatic disease and I think that the disease process and background are similar but the soil is different. We have seen, and I'm sure Dr. Crohn has also, patients with involvement of the entire small intestine and colon simultaneously. We now have two patients with enteritis whose mothers have ulcerative colitis.

DR. CROHN: COMMENT: I have a family with regional ileitis in one member, ulcerative colitis in

another member, segmental colitis right-sided colitis in the third member and duodenal ulcer in the fourth.

Q. Are the eye findings in regional ileitis more significant in regional ileitis than in ulcerative colitis?

DR. CROHN: Eye findings in regional ileitis are less significant; they are much more significant in ulcerative colitis particularly in right-sided segmental colitis. Xeropthalmia, or vitamin "A" deficiency, phylctenular conjunctivitis is very common in ulcerative colitis. Conjunctivitis, iritis, iridocyclitis and corneal ulceration, are all very common manifestations of ulcerative colitis, right-sided colitis and to a lesser extent of regional ileitis. It is something that the ophthalmologist has learned with a great deal of pain over a long period of time. We have seen actual blindness due to bilateral corneal ulceration in a man who was treated by an ophthalmologist for years; and nobody remembered to think that this man was suffering with diarrhea all the time.

Q. TO DR. CROHN AND DR. MACHELLA: Would it not really simplify the management of non-specific inflammatory diseases if the clinician regarded regional ileitis and ulcerative colitis as actually one disease. The differences in pathology and the differences in the clinical course being merely differences due to the location of the inflammatory regions.

DR. MACHELLA: That is exactly the way I feel about the two diseases. There is, however, one point that disturbs me about the attitude. Dr. Crohn might be able to clear this up since he has had a more extensive experience than I have. If there is anything to the predisposition to carcinoma in ulcerative colitis and it looks like there probably is, why don't we see carcinoma of the small gut in regional enteritis?

DR. CROHN: Dr. Shields Warren who delivered a paper at the AMA last June in Chicago, made the point that they are two entirely different diseases. Ulcerative colitis is one disease and regional ileitis another. In my discussion of his presentation I could not agree. I thought there are so many similarities pathologically and clinically between the two diseases that I couldn't completely separate the two.

Dr. Machella noted cases which began with ulcerative colitis, which ran a severe course of ulcerative colitis and suddenly developed a diffuse ileojejunitis as a complication. In a case seen some years ago an ileostomy and colectomy had been performed on a case of ulcerative colitis. An attempt to take down the ileostomy and replant it in the sigmoid colon resulted badly. Within three weeks the ileostomy had to be restored. At the time of the reestablishment of the ileostomy the surgeon was amazed to find a diffuse ileojejunitis. Also you see cases which beginning as ileitis, do badly, and end up with a progressive ulcerative colitis. Or one sees cases which begin originally as combined ileitis and colitis with various mixed forms. There are, however, differences in clinical manifestations of the two diseases. For instance, in women ulcerative colitis, the severity of the course is characterized by skipped menstruation, amenorrhea. The prognosis and severity of the disease in ulcerative colitis can be judged by the degree of menstrual disturbance or the degree of amenorrhea.

The first reappearance of menstruation is the best prognostic symptom. As soon as normal menstruation is reestablished the prognosis becomes favorable. No matter how bad a case is of ileojejunitis, she rarely skips a menstrual period.

Take the question of pregnancy and parturition. The ileitis case or the ileojejunitis case goes through pregnancy perfectly well; will deliver a perfectly normal child and will probably not have a recurrence of the disease. If she hasn't had a recurrence during the pregnancy, she probably will not have a recurrence later. On the other hand, I know of nothing worse than pregnancy in ulcerative colitis. During the course of pregnancy they may be well, and

the diarrhea is controlled. Within three weeks or a few weeks after the delivery of a child, the ulcerative colitis patient has a tendency to have a recurrence of all the symptoms with marked severity.

There are similarities and there are marked clinical differences but behavior of the two diseases toward pregnancy and parturition particularly and the behavior of menstruation is to my mind a very definite differentiation between the two types of disease.

Q. Would either essayist comment on when the continuity of the bowel would be reestablished after an ileostomy was performed?

DR. CROHN: You were probably too young to be present at the American Gastroenterological Association, when Dr. Daniel Jones of Boston was alive and was doing ileostomies without colectomy. Dr. Jones was asked:—have you ever taken down an ileostomy and reconnected it? And Dr. Jones who had a very keen sense of humor said, "Yes, I have, five times. Twice the patient died; the next two patients were materially worsened by taking down the ileostomy and the fifth one, I never heard from and never want to."

DR. MACHELLA: My answer to that would be to take down the ileostomy and re-establish continuity only if the emotional factors had been solved. The patient then might have a good chance of getting along unless something else turned up and upset him. The same sort of thing applies to pregnancy. If the woman wants to become pregnant and wants the baby, she will do well; if she doesn't, she will do poorly.

ARTICLES OF INTEREST

MULTIPLE SCREENING

Its Place in the Baltimore Chronic Illness Study

DEAN W. ROBERTS, M.D.* AND CHARLES M. WYLIE, M.B., CH.B

The Commission on Chronic Illness is a temporary national, non-governmental, research and educational organization founded in 1949 by the American Medical Association, the American Public Health Association, the American Public Welfare Association, and the American Hospital Association.

A number of new clinical problems have been added to the already numerous complexities of the study of chronic illness in Baltimore, first described in the pages of this JOURNAL over a year ago.[1] The final phase of this study is the operation of a so-called "multiple screening" clinic, being arranged for the Fall of this year. The purpose of this article is to describe some of these clinical problems.

The idea of screening for signs and symptoms of a disease is already well known to Baltimore physicians. There has not been, however, any prior experimentation here with multiple screening although the process has been tried in Richmond, Indianapolis, and Atlanta, to name a few other cities.

Before describing some of the clinical problems we are encountering, a progress report on the earlier phases of the study is in order so that the purpose of the screening clinic can be best understood. Much has happened since this study carried out by the Commission on Chronic Illness was first described[2] in the JOURNAL. Approximately 4000 households, chosen to be representative of the City of Baltimore and including 12,000 persons, have been interviewed by trained lay interviewers who have recorded in detail the illness and disability reported. This phase of the study was completed early in September with a most gratifying response from Baltimore householders. The interviews required an average of about 40 minutes each. Based on the first nine months of the survey, the interviews were successfully completed in 97.6% of the households, the occupants could not be located in 2.1%, and 0.3% declined to be interviewed. This high response rate is important to the statistical reliability of the data obtained.

This phase, which is now complete, included very little that was new or different from previous illness surveys. However, such surveys leave unanswered a number of important questions about chronic illness: To what extent do people actually have the conditions they report to a lay interviewer? Do they fail to report conditions of which they are aware? Does the informant, usually the housewife, have accurate and reliable knowledge of the health conditions of other members of the family? How much chronic illness exists that is not reported because it had not yet been diagnosed? To state it broadly—what is the kind and degree of error—resulting from under and over reporting—in statistics derived from household interview surveys of illness?

CLINICAL EVALUATION STEP

In order to answer these questions and to study the kind of care needed by the chronically ill, arrangements were made for a detailed clinical evaluation of a sub-sample of approximately 10% of those persons in the household interview step. A special evaluation clinic was established for the purpose at the Johns Hopkins Hospital which undertook the evaluation through a contractual agreement with the Commission on Chronic Illness. The evaluation was designed to provide a comparison between illness data derived from systematic household interviews and corresponding data derived from a careful medical work-up supplemented by laboratory tests, specialist consultation, and medical data obtained from private physicians and hospital records. The

* Director, Commission on Chronic Illness.

[1] The following is quoted from the minutes of the Council of the Medical and Chirurgical Faculty of April 27, 1953: "Council unanimously approved the study in principle, and suggested further that in order to render additional assistance, appropriate information be published in the Maryland State Medical Journal."

[2] Roberts, Dean W., Maryland State Medical Journal, June 1953, p. 297.

medical work-up would be a fairly close approach to an absolute determination of the illness status of the person within the limits imposed by current medical knowledge, available tests, etc. It would also permit a consideration of the degree of disability, the potentialities for rehabilitation and the kind of care needed, which was not possible from the sketchy information available from interview data alone. By mid-July 385 persons had been evaluated, out of the 1000 for whom this procedure was planned.

The evaluation step has been full of surprises and no small number of disappointments. It is the novel part of the study and also the most important part. The first (and continuing) difficulty was in persuading selected individuals to come to the evaluation clinic. It had been assumed, perhaps naïvely, that people would welcome the opportunity to get a thorough diagnostic evaluation as a part of the study. This has been true, only for a small group. Of those invited to the clinic 31% have been classified as outright refusals. This figure is not quite as bad as it at first sounds. It includes a substantial group who have moved away from the city or to a new address that could not be located, also a small group who died after being included in a household interview, a few Christian Scientists, and a substantial group who were obviously too disabled or ill to undertake a trip to the clinic.

Other refusals can best be described in terms of "attitudes" toward medicine, hospitals, and doctors. Some related previous disagreeable experiences with clinics. Others had a complete lack of confidence in physicians. Some were afraid they would be "experimented" on. A few mothers did not want their teen-age daughters "examined" and refused to come even though assured that the gynecological examinations would be omitted. A rather large group declined on the basis that they felt well and they saw no point in an examination unless they were sick. Some would have come if the clinic had offered treatment, but refused when it was made clear that the evaluation clinic was limited to diagnostic examination. One of the larger and most interesting groups of refusals were those who stated or implied, "If there is anything wrong with me, I don't want to know about it." This was predominantly an elderly group and may represent an attitude that goes with advanced age. Or they may be persons who are unaware of medical advances and who lack an appreciation of what modern medicine can do to help them. In any event, they probably represent the kind of person who does not seek medical care until illness is far advanced and beyond the stage when treatment can be most effective.

There also have been persons who declined the evaluation because they are under regular periodic medical supervision. These individuals see no personal advantage in an additional examination. In such cases it has sometimes been possible to get sufficiently detailed and complete information from the personal physician to fulfill the requirements of the study for evaluation data. However, such information is not fully comparable to that obtained in the evaluation clinic where examination procedures, laboratory tests, and measurements of vision, hearing, blood pressure, etc. have been substantially standardized.

Several hundred Baltimore physicians have been in contact with the study in relation to their private patients. At the time of household interview, if illness is reported, the name of the physician in attendance is obtained. Permission to get additional medical information from the doctor is requested. If that person falls in the 10% sample selected for clinical evaluation, a personal letter is sent to the physician. In a few days the letter is followed by a telephone call.

The purpose of the telephone call is to obtain any pertinent information from the physician as to the nature of the illness and the resultant disability and to determine whether or not there is any reason why the patient should not be invited to come to the clinic. In some instances there are distinct medical contraindications to a clinic appointment such as when persons have a history of a recent coronary occlusion and when they are aged and the personality of the patient is such that the physician has asked that the patient not be invited to the clinic. In a great many instances when the patient has hesitated to come to the clinic, the family physician has urged attendance and has convinced the patient to come in.

This report would be incomplete if it did not add that in three or four instances the reaction of the family physician to the study has been unfavorable in that he felt that the evaluation in the clinic interfered with his relationship to his patient. Such reactions were usually the result of misinformation or a lack of information about the study and clarification

has not been difficult. If for any reason a physician requests that a particular patient of his not be invited to the clinic, this request is honored. Fortunately there have been only a few such cases—if there were many they would reduce the "representativeness" of the sample and thus the value of the data.

Plans for the Multiple Screening Step

This Fall the study moves on to another step which promises to pose many problems. Multiple screening has been tried in many sections of the country and has been variously described. Some have regarded it as a major instrument in the detection of asymptomatic chronic disease, and thus an important aid to treatment early in the course of disease when the prospect of success is greatest. Others criticize screening on the basis of the expense, the mental anguish caused by false positive reports, the false sense of security in the person whose tests are all negative, the injection of a third party into the physician-patient relationship, and the inadequacy of the tests that are currently available.

The Commission on Chronic Illness, a national research and educational agency, will close its books and go out of existence in less than two years. Before winding up its affairs it will need to make a critical assessment of multiple screening in order to formulate properly its recommendations. This assessment will involve a careful review of the experience reported by others and, in addition, a direct exploration of certain problems and possibilities in a screening step conducted as a part of the Baltimore Chronic Illness Study.

The Purpose of Screening

For some years the miniature film chest x-ray clinics have screened out those persons who needed further examination for possible tuberculosis. Annual diabetes detection clinics have sorted out persons who required additional study for diabetes. For the first time in Baltimore, however, a combination of several tests will be used experimentally in one clinic to screen for a number of abnormal conditions.

Multiple testing has the same goals as testing for a single disease, i.e. the early detection of certain conditions which might benefit from immediate medical care, and the referral of persons possibly having these conditions to their personal physician for further diagnosis and treatment if necessary. Multiple screening may prove to be an important tool in the control of chronic disease, where early detection may result in successful treatment before an irreversible phase of the disease is reached.

It might also be mentioned that multiple screening is an adjunct to the annual physical examination procedure. It can have value in that the physician's time is conserved by enabling him to concentrate his efforts on persons who are more likely to have disease or abnormalities.

At the Baltimore multiple screening clinic there will be no physical examination. The following tests will be given: electrocardiogram, chest x-ray, blood pressure reading, height, weight, urine and blood sugar determinations, tests for albuminuria and hemoglobin level, serological test for syphilis, vision and hearing tests and a dental examination.

Several other tests were considered for inclusion but were discarded either for technical reasons or because it did not appear that they would contribute materially to the information needed by the Commission. In the selection of the tests to be used, the method of their use, the interpretation of the findings and the manner of making reports to patients and physicians, the Commission had the advice of a technical committee[3] composed primarily of practicing physicians who reviewed the prospectus for the project and made many valuable suggestions. Among the tests discussed at length by the Committee were those related to heart disease. These include the electrocardiogram, heart size and shape as revealed by chest x-ray, blood pressure and two questions designed to ask about symptoms of exertional discomfort.

The EKG

The electrocardiograph has been in use for many years. With the introduction of unipolar limb leads and chest leads, the total procedure has now become too time consuming to be suitable for rapid application to large groups of people. It has been found elsewhere,[4] however, that when the lead I tracing alone is used as a screening test, approximately the

[3] Dr. Lewis P. Gundry, Dr. Edwin B. Jarrett, Dr. Louis A. M. Krause, Dr. Joseph L. Lilenthal, Dr. Henry J. L. Marriott, Dr. Perry F. Prather, Dr. Raymond K. Thompson, Dr. Huntington Williams and Dr. George H. Yeager.

[4] Dawber, T. R. et. al. Circulation 5: 559, 1952.

same number of cases of heart disease can be detected as if a 12 lead EKG had been taken.

The increased accuracy of the twelve lead EKG becomes apparent, not on the persons who have heart disease, but on those who are normal. Twenty per cent of persons without heart disease are classified as "doubtful" or "abnormal" with the lead I tracing alone. Many fewer persons without heart disease, however, are classified as "doubtful" or "abnormal" if the twelve leads have been taken.

It is apparent that the lead I test, resulting in the wrong referral of almost 20% of all persons going through the clinic, would be quite unsatisfactory by itself. The defect can be overcome, however, by carrying out a more thorough EKG on those whose lead I tracings appear suspicious. In this way, the time-consuming test is carried out only on one-fifth of the persons, with almost the same number of cases being detected and without the burden of an excessively large number of false positives.

This test illustrates the problem of false positives which applies in varying degree to all screening tests. The lead I EKG, used in the above manner, may wrongly refer about three false positives for each case of heart disease correctly referred. This could produce a heavy burden of unnecessary mental suffering if these persons with a normal heart were given the wrong impression, even though later corrected, that something was wrong with their hearts. They also could properly complain of the expense of establishing the absence of heart disease after a test had wrongly raised a doubt. To reduce such false positives to a minimum, the 12 lead EKG will be carried out on all persons with a doubtful lead I tracing before the person leaves the clinic. As a further guard against unnecessary worry, the clinic will emphasize that a positive test does not make a diagnosis, but merely indicates the need for further examination and testing by their personal physician. A basic rule of the clinic procedure is that all abnormal test results are sent to the family physician for interpretation to the patient.

The Chest X-ray

Second in the tests for heart disease is the miniature film chest x-ray, in which changes in heart size and shape will be noted. It is well known, of course, that this is an insensitive test. Many cases of heart disease and hypertension show no detectable heart enlargement. Some additional cases will be found, however, who were missed by the electrocardiogram.

The Blood Pressure

The third test for heart disease and hypertension is the blood pressure reading. The difficulties involved in this test are only too well known. The lack of agreement on what are normal values ranges from Robinson and Brucer's belief that 120/80 is abnormal at any age[5] to the investigation by Master et al.,[6] suggesting that 160/100 can be normal around the age of 50. One of the values of including this test is that we will obtain, under standardized conditions, the blood pressures of a random sample of the adult population of the city.

Involved also in the difference of opinion on blood pressure is the realization that although a significant number of persons in their fifties have readings of 160/100, this does not necessarily mean that such a reading is conducive to a long and active life. This once again brings to light the old controversy that the aim of medical supervision is the maintenance of optimum values, not of average values. Many physicians, on the other hand, can bring individuals to mind with extraordinarily high blood pressures who are capable of a hard day's work.

What is Hypertension?

Not too widely known is the fact that the obese arm is likely to give systolic and diastolic readings which are too high. This error may exceed 30 mm. of mercury.[7] It is suggested that this should not effect the level at which overweight persons are referred. An obese person with a raised sphygmomanometer reading will be helped by a reducing diet, whether a true hypertension is present or not.

The blood pressure levels above which persons will be referred to their physicians as possible hypertensives have been made higher for older age groups at the screening clinic. Below 35 years of age, any person will be referred whose blood pressure is over

[5] Robinson, S. G. and Brucer, M. Arch. Int. Med. 64: 409, 1939.

[6] Master, Garfield & Walters: Normal Blood Pressure & Hypertension: New Definitions. Philadelphia (Lea & Febiger, 1952).

[7] Ragan, C. & Bordley, J., Bulletin. Johns Hopkins Hospital 69: 526, 1941.

150/90 mm. Hg. Between 35 and 50 years, a critical level of 160/96 will be used. Over 50 years, a pressure above 170/100 will result in referral to the family physician. Figure 1 compares these screening levels with the data collected by Master, Garfield and Walters.[6a]

Symptoms of Heart Disease

Considerable study has been made of the use of questions concerning symptoms of "heart disease" in screening for these conditions. Only two questions have been found to have any degree of specificity in testing for cardiac disabilities.[8] These questions, both related to discomfort on exertion, are: (1) "Do you ever have distress, pain or an uncomfortable feeling in the chest while walking on the street or up inclines or steps?" And (2) "While walking, are you forced to stop in order to rest?" A positive answer to both questions will result in referral to the family physician.

It can thus be seen that four different types of tests are being used in screening for heart disease and hypertension: 1) The electrocardiogram, 2) The chest x-ray, 3) The sphygmomanometer reading, and 4) Symptoms of heart disease. While each of these tests will pick up only certain types of cases, all four, particularly if used in combination, should be successful in screening off the major proportion of cases who require medical supervision. It is estimated that the 7,000 persons who will be invited to this clinic will include about 280 previously unknown cases of heart disease and hypertension.

Screening for Obesity

It can be argued that there is no point in screening for obesity. If a person is substantially overweight, he probably knows it and certainly his physician does—if the individual has a physician! On the other hand, the recent evidence on the importance of obesity in relation to heart disease, diabetes, arthritis, hypertension, and longevity in general seems to warrant inclusion of measurement of height and weight in the tests. Persons who are 30% or more overweight will be urged to seek medical advice from their physician. Those who are 20% to 30% overweight will be referred if some other condition,

[6a] Ibid. page 560.

[8] Phillips, E., et al. Amer. H. J., 45: 3, 1953.

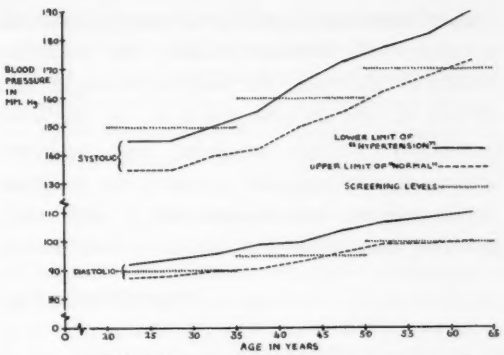

FIG. 1. Relation of screening levels to upper limits of normal blood pressure and lower limits of hypertension (averaged for males and females).

such as family history of diabetes, emphasizes the need for strict weight control. Lesser degrees of obesity will be called to the attention of the person for their information.

Tests for Diabetes

Limitations of space prevent a detailed account of all of the other tests. Among the most difficult to handle are the tests for diabetes. Both blood sugar and urine sugar will be tested, but it will be impractical to ask people to come to the clinic in a fasting state. Persons with a urine sugar level of one plus or more, or a blood sugar level of 160 mg.% (or 130 mg.% if no food is taken within one hour before attending the clinic) will be offered a glucose tolerance test at a later date; those with an abnormal curve will be referred to their family physician.

The Time and Place

It is planned to operate the screening clinic for a limited period of about 10 weeks probably beginning about October 4. This is a single experimental clinic and there is no thought to continuing it as a service program. Dr. Robert H. Riley has graciously consented to allow the Commission on Chronic Illness to use Bennett Hall at 20 East 23rd Street for the Clinic. Those persons (approximately 7000) who were included in the household survey, who are over age 16 and who were not in the evaluation sample will be invited to come in on an appointment basis. There is adequate parking space and a person should be able to complete all the tests in about an hour.

The Commission needs the active support of the physicians of Baltimore during the remaining months of this study. The study is a complex and difficult one and we hope that it can be completed successfully without producing any problems between doctors and their patients. We recognize certain inherent hazards, however, in any study gathering detailed medical data on a cross section of the population of the city. If any incident for which we are responsible develops with one of your patients, we hope you will call it to our attention in order that we may endeavor to rectify the situation. (Telephone PEabody 2-7133.) Data from this study will be of interest to the medical profession and will be particularly useful in helping Maryland make appropriate plans dealing with the mounting problem of chronic illness.

PRISONER OF WAR RETURNS*

CAPTAIN WILLIAM SHADISH

Physician
POW Camp
North Korea

It seemed incredible to me that I had missed something. Like all other good and true alumni I believed that my school ranked right up there on top. The curriculum was thorough and complete. But I found out differently. The Communists pointed out to us that something had been neglected in our medical training. It was like this.

We had been prisoners of war for a good many months and hadn't seen a scientific medical publication in all this time. We approached our captors in an attempt to procure any type of medical literature, so that we might keep the cobwebs from our minds. The answer we received in essence was this: "We communists feel that there will be much time for your study of medicine in the future, but while you are here with us we shall give you the opportunity to learn the most important factor in medicine.—Whom shall you treat and save from death and whom shall you not treat. You do not seem to realize that medicine, like everything else in life, without exception, cannot be divorced from politics. Everything is primarily political in nature. The other purposes are secondary." What a revelation! It would seem the Hippocratic oath has been rewritten in the Soviet countries.

In all there were nine American physicians who were captured by the Communists—five survived. Since repatriation the question most asked has been, "Were you allowed to practice your profession in the prison camp and were you regarded as a physician?"

You be the judge. Briefly, this is what happened.

In the beginning the enemy seemed to have no definite plan for providing medical care for the prisoners. During this period, roughly 6–8 months, we were permitted to care for the sick and wounded under existing conditions. These were:

1. Extremely poor diet—almost entirely carbohydrate with caloric content at or below basal requirement.

2. Bitterly cold climate often beyond minus 30 degrees Fahrenheit.

3. Pathetically insufficient clothing—no blankets or bedding of any kind and heavy outer clothing was at a premium.

4. Primitive housing, often open to the environments, with heat practically unheard of.

5. Shocking lack of sanitation facilities—not even shovels available for digging latrines in the frozen ground.

6. Extremely high rate of diseases—most common were dysentery, both bacillary and parasitic in origin, and lobar pneumonia. As one would expect with troops in a state of severe malnutrition, the mortality rate was astoundingly high. In one camp called Death Valley, where I was interned, the mortality rate of the prisoner group was between 60% and 70%.

7. A negligible amount of medication and surgical equipment—enough for treating only 1% or 2% of those requiring medicine or treatment.

As difficult as the problems were, the Communists continually made things worse. They insisted on supervising our work at all times. Any medications prescribed were dispensed only by the Chinese.

* Reprinted by courtesy of the Alumni Bulletin of the State University College of Medicine at New York City.

Invariably the medications were either refused completely or cut in volume so drastically that they could no longer serve their purpose. This was especially true when the patient was one who steadfastly resisted the efforts of Communist indoctrination. In these instances particularly, were improvisations necessary; such improvisations even though of little specific medical value, did much towards boosting the morale which was fearfully low. In fact this morale boosting constituted the most basic aim of our practice in this early period. We had little else to work with.

In July 1951, about 8 months after capture, we physicians were relieved of our medical duties by the Communist authorities and sent to the officers' compound "for study." From this time forward we were specifically forbidden to practice medicine in any manner at any time. We did continue to administer to those fellow prisoners who required aid, but of necessity this was done in secrecy and, of course, without a legitimate source of medicine.

About this same time a somewhat larger supply of medications became available. These were administered by Chinese medical students none of whom were as competent as a good Army medical corpsman. The food also improved to at least a minimal diet, calorically speaking, and some little protein and vegetables were added from time to time. The mortality rate of course decreased rapidly to practically nothing, although the state of nutrition was such that dietary deficiency diseases were evident in most prisoners right up to repatriation.

What is most infuriating is that the deprivation was deliberate. Tons and tons of propaganda materials, books, magazines and newspapers, including the "New York Daily Worker," reached us. And yet we heard "no transportation available for food or medicines." The Marxist-Leninist literature explains this. For instance it is pointed out that when "a group of subjects are reluctant to accept (Communist) indoctrination, the most effective method of dealing with them is first to deprive them of the necessities of life to a point that is sub-minimal, and then to offer a slow steady increase in these necessities contingent upon at least passive acceptance of the program. Steadily recalcitrant individuals can be controlled by individual "corrective measures." "Corrective measures" is a Communist term for torture, death or both.

These experiences have left an indelible impression upon me. The Communists did their utmost to teach us whom to treat and who did not merit treatment. But somehow we remained unimpressed. Murder, deceit and fabrication do not appeal to mature minds reared in our environment of freedom.

WILLIAM R. SHADISH
Captain, MC, USA
10306 Insley Street
Silver Spring, Maryland

INDIAN COMMISSIONER SEES IMPROVED HEALTH UNDER HOSPITAL TRANSFER

The A. M. A. Washington Letter, No. 85

Commissioner of Indian Affairs Glenn L. Emmons believes that the law transferring supervision of Indian Bureau (Interior Department) hospitals to Public Health Service (Department of Health, Education, and Welfare), effective next July 1, will go a long way toward alleviating poor health conditions in Indian areas. Many of these areas, he declared in an address, have been "practically untouched by the great advances in public health protection which have taken place throughout the country during recent decades." He said the Bureau for several months has been building up the staff of professional sanitarians, health educators and other health specialists in preparation for the changeover next year. The Indian bill is among the administration health measures endorsed by the American Medical Association.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

The annual outing of the Allegany-Garrett County Medical Society was held on Wednesday, August 4, at the cottage of Dr. C. C. Zimmerman, at Deep Creek Lake.

Food was prepared and served under the direction of Dr. Fuller Whitworth and Dr. Frank Cawley. Boating and swimming arranged by Dr. James Stegmaier, and social arrangements and games under the auspices of Drs. James Hallinan and Howard Tolson.

The last of July Dr. Arthur Jones assumed his duties as the Garrett County Health Officer.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

SECTION ON INTERNAL MEDICINE*

THE COMMITTEE FOR A RESOLUTION REGARDING THE PROPOSED BETHLEHEM STEEL PLAN, authorized to act for the Section on Internal Medicine of the Baltimore City Medical Society, have carefully reviewed the proposed Plan for Bethlehem Steel employees per letter April, 1954 from the Maryland Medical Plan, Inc. requesting a vote for or against, and inviting comments. Comments and recommendation are respectfully submitted to you for transmittal to the President and Trustees of the Maryland Medical Plan for consideration.

The Section on Internal Medicine is in favor of the principle of prepaid medical care. It is the sincere desire of the Section on Internal Medicine to cooperate to provide the highest type of medical care at a fair and reasonable cost to the subscribers.

* As presented to Francis Gluck, M.D., Chairman, Section on Internal Medicine.

It is the studied opinion of the Committee that every prepayment plan should aim to provide the broadest possible coverage.

The proposed plan for Bethlehem Steel Employees contains certain inequities and shortcomings which we believe operate against the best interests of both subscribers and specialists in the field of Internal Medicine. In so doing it fails to provide the highest type of medical care.

First and most important is the fact that the plan fails to recognize the existence of specialists in Internal Medicine and related subspecialties. This is unrealistic and is contrary to accepted, current medical practice. The attached copy of requirements for admission to examination by the American Board of Internal Medicine points out the minimum fund of experience and training that the Internist must bring to bear in the treatment of patients. These requirements are as stringent and demanding as any set down by any certifying board in the surgical specialties. The period of postgraduate training is as long and arduous for the Internist as it is for the Surgeon. Additional training and certification in Internal Medicine is required for admission to examination by appropriate Boards in the subspecialties.

It is the opinion of the Committee that any Plan that does not provide for care by specialists in Internal Medicine and its subspecialties fails to provide adequate care for the seriously ill patient. Often Internist or qualified Subspecialist is summoned to make the investigation necessary before correct and effective therapy can be instituted.

The Bethlehem Steel Plan obliquely recognizes the existence of specialists in fields other than surgery by providing a $15.00 consultation fee, but there are no criteria for consultants. Furthermore, the Plan fails to provide for a patient treated directly by a specialist in Internal Medicine or subspecialty.

The question of the benefit to participating specialists in Internal Medicine and subspecialties is, under the circumstances, not considered in the proposed plan. However, these specialists are called

by their colleagues in Surgery or General Practice to provide consultations. The benefit provided for such consultation, upon the quality of which the patient's life may depend is the same as provided for removal of a splinter by a surgeon. It is $20.00 less than provided for the aspiration of the pericardial sac. The Internist is as well qualified to perform such aspiration as the general surgeon, but he cannot be paid for it under the proposed plan.

It is the opinion of this Committee that in consideration of what has been stated above, the inequities of this benefit schedule need no further elaboration. Therefore, in view of the above, serious shortcomings of the proposed Plan, this Committee makes the following recommendations:

1. A distinction should be drawn between Specialists in Internal Medicine and General Practitioners. For the purposes of the Plan an Internist should be defined as a physician certified, or declared eligible to be admitted to examination by the American Board of Internal Medicine; and/or a physician who is a Member of the American College of Physicians. Furthermore, for the purposes of the Plan, appropriate authority in the Medical Schools in the City of Baltimore may designate any teaching staff member in the Department of Medicine, or subspecialty, as an Internist.

2. Provisions should be included in the proposed Plan for benefits for care by specialists in Internal Medicine and subspecialties.

3. Provision should be made for a Benefit Schedule for specialists in Internal Medicine and subspecialties, in keeping with the type of service rendered. The scale for Medical Specialists should be on a par with that for Surgical Specialists and distinct from the one for General Practitioners.

4. That funds for the above should be made available by adjusting the current or proposed Benefit Schedule without increasing subscribers rates.

5. That representatives of the Maryland Medical Service, Inc., and this Section on Internal Medicine meet to adjust these matters.

The Committee of the Baltimore City Medical Society for a Resolution Regarding the Proposed Bethlehem Steel Plan, June 29, 1954.

CONRAD ACTON, M.D., *Chairman*
KATHERINE BORKOVICH, M.D.
JACK WEXLER, M.D.

THE AMERICAN BOARD OF INTERNAL MEDICINE

Requirements for admission to Examination and Certification

Each applicant for certification by this Board must satisfy the qualifications listed below. I) General Qualifications A, B, C, D. II) Professional Qualifications A, B, C, D. For exceptions to the requirements C and D under Professional Qualifications, see Page 3, Paragraph G.

I. *General Qualifications*

A. All candidates must be citizens of the United States or Canada.

B. All candidates must present evidence of satisfactory moral and ethical standing in the medical profession.

C. All candidates must be active members in good standing in their County and State medical societies in their state of legal residence. Under unusual and exceptional circumstances the Board reserves the privilege of modifying this requirement. . . .

D. Canadian citizens applying for admission to examination must be active members of the Canadian Medical Association.

II. *Professional Qualifications*

A. Graduation from a medical school approved by the Council on Medical Education and Hospitals of the American Medical Association at the date of graduation.

B. Satisfactory completion of an approved interneship of not less than twelve months. . . .

C. Approved residency or fellowship training in internal medicine according to the following plan (Plan A) or one of the alternate training plans. . . .

Plan A. a residency or fellowship in internal medicine for a period of not less than three years in a hospital or other institution approved by the Council on Medical Education and Hospitals of the American Medical Association for residency or fellowship in internal medicine. In addition, two years of practice of clinical internal medicine will be required. The Board will accept the following equivalents as satisfying one year only, of the three years of residency or fellowship to which this paragraph refers:

1. A second year (or a part thereof) of approved interneship in a hospital approved for resident training in internal medicine if limited to the medical service (or medical specialties noted under 2) for one year and if recognized as being the equivalent of an assistant residency by the Medical Director of the hospital and the Chief of the Medical Service.

2. One year of approved residency in one of the medical specialties: Allergy, Cardiovascular Disease, Gastro-Enterology, Hematology, Pulmonary Diseases, Neurology, Pediatrics, and Psychiatry.

3. One year of approved residency in Pathology.

4. One year as a graduate student or as an instructor in an approved medical school on a full time basis in Bacteriology, Biochemistry, Pathology, Pharmacology, Physiology, or Internal Medicine.

5. An advanced degree in the fundamental sciences.

D. Alternate Training Plans: The Board firmly believes that the plan of intensive training prescribed above offers the

best opportunity for a young physician to prepare himself to meet his responsibilities as a specialist in internal medicine. It is recognized, however, . . . Accordingly the Board has modified its previous regulations governing eligibility for admission to examination. In doing so the Board has not modified its standards of examination. . . .

Principles of Training

The American Board of Internal Medicine is interested in the fact that the candidate has embarked on a career of study voluntarily and has thereby expressed the desire to excel and to participate personally in the world's progress in Medicine.

Preparation must be based on years of continuous thoughtful study. Therefore, in suggesting a program for those who wish advice, the Board hopes to assist the candidates to avoid inferior and superficial programs which may lead to failure and disappointment in later years.

The Board believes that all internists should have a sound fundamental knowledge of Anatomy, Bacteriology, Biochemistry, Pathology, Pharmacology, and Physiology. Such knowledge is essential to the continued progress of any internist. The Board anticipates that adequate training will be obtained in the basic sciences as applied to internal medicine during a formal three year residency program.

The Board wishes to emphasize that time and training are but a means to the end of acquiring a broad knowledge of internal medicine which the candidate must demonstrate to the Board in order to justify it in certifying that he is competent to practice internal medicine as a specialty. The responsibility of acquiring the knowledge rests with the candidate. The responsibility of maintaining the standards of knowledge required for certification devolves on the Board. . . .

MONTGOMERY COUNTY MEDICAL SOCIETY

DEWITT E. DELAWTER, M.D.

Journal Representative

On Thursday July 29, 1954 the Montgomery County Health Department employees gave Dr. V. L. Ellicott a farewell dinner at the Indian Springs Country Club. At the dinner Dr. Robert A. Hare, President-elect of the County Medical Society presented Dr. Ellicott with a desk set from the Society as a farewell gift in remembrance of the fine cooperation that has existed between the Society and the local health department.

Dr. Ellicott began his new work on August 1, 1954 as director of the Department of the Aged and Chronically Ill of the State of Maryland. The Society wishes him success and happiness in his new position.

Dr. K. F. Welte has left the local Chest Clinic to take a new position in Cleveland. Dr. Allen J. O'Neill has taken over the operation of the Chest Clinic.

The President of the Society has appointed Dr. George Sharpe as Chairman of the Diabetes Detection Drive for this year. He will work with interested lay groups in the conduct of the drive. It is hoped that all physicians will give Dr. Sharpe their complete support in this national effort to detect Diabetes.

The President and Secretary of the Society appeared before the County Council in July to request that the local physicians be consulted in the selection of a new health officer for Montgomery County. Our representatives were warmly received and told that their interest and recommendations would be appreciated. A member of the Society has been appointed to serve on a committee for the purpose of reviewing applications and making a recommendation to the County Council.

The coming programs for the Society are as follows:

October 19, 1954—Place—Clinical Center, National Institutes of Health, Bethesda, Maryland.

Program

7:00 p.m. Dinner—Cafeteria
8:00 p.m. "Infectious Hepatitis"—Auditorium
Dr. Norman B. McCullough, Chief, Laboratory of Clinical Investigation, National Micro Biological Institute.
Business Meeting to follow.
November 16, 1954 Dinner Dance—Woodmont Country Club.

The Medical Library of the National Institutes of Health has been made available to the members of the Society on the same basis as to the members of the staff of the Institutes. This is one of the finest and most up-to-date libraries in the Country and we are fortunate to have it in our County to serve as a supplement to our State Society Library in Baltimore.

WASHINGTON COUNTY MEDICAL SOCIETY

SIDNEY NOVENSTEIN, M.D.

Journal Representative

The regular meeting of the Washington County Medical Society was held in conjunction with a picnic at the Potomac Fish and Game Club, Williamsport, Maryland.

Members of the Washington County Dental Society were also invited.

By majority vote, the Society approved the suggestion by the Medical and Chirurgical Faculty that annual dues be collected by the State Society instead of the County Society.

No action was taken by the Society on the matter of the insignia for each Society, as desired by the State Journal.

Malpractice insurance coverage for physicians was discussed and a committee appointed to investigate the rate charged for this type of insurance; and amount of coverage underwritten.

HOUSE COMMITTEE URGES 'FAIR TRIAL' FOR NEW VA ADMISSION POLICY

AMA Washington Letter, No. 64

A resolution adopted by the House Veterans Affairs Committee outlines the committee's attitude toward eligibility of veterans for medical care by Veterans Administration. These points are made:

1. The committee approves (a) the present unlimited hospitalization of service-connected cases, (b) the continued hospitalization of non-service neuropsychiatric and TB cases, and (c) the continued hospitalization of other non-service cases "where beds are available and the veteran does not have the ability to pay for private hospitalization."

2. The committee urges "all veterans' groups and all other parties interested in medical care for veterans" to defer final conclusion on eligibility until the new VA admission policy "has been given a fair trial and a period of operation." Meantime, the committee recommends that no new legislation be considered on the subject of eligibility of admissions.

(In November, 1953, the VA put into effect a new 10-P10 form addendum on which the veteran applying for care of a non-service-connected condition would be asked to list his assets and liabilities. Under the law, however, VA cannot deny admission on the basis of information furnished on the form.)

In its resolution the committee notes that a subcommittee, under chairmanship of Bernard W. (Pat) Kearney (R., N.Y.), last year conducted hearings for a month on the subject of entitlement and eligibility. The committee emphasizes that the subcommittee took testimony from veterans' groups, medical societies (including AMA) and government officials. The committee's resolution is in effect an indorsement, for the time being, of the official policy of the Veterans Administration.

The American Medical Association policy on eligibility of veterans would limit the medical care of veterans to two groups: 1. Those with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated. 2. Within the limits of existing facilities, veterans with wartime service suffering from tuberculosis or psychiatric or neurological diseases of non-service origin who are unable to pay for hospitalization. VA should care for the latter group only until non-government facilities are adequate to assume the responsibility. Care of other non-service-connected cases would be the responsibility of the veteran himself or the community.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

LIBRARY CHATTER

MARY EMILY BERGE

Dr. G. Lane Taneyhill, shortly before his death, presented the library with a collection of books on psychiatry and psychoanalysis including a number of original German works by Freud and his colleagues. They represent an addition to our collection in a field where we are particularly weak. Anyone interested in consulting source material along these lines should find them useful.

Summer's heat and summer's vacations are alike behind us and everyone is back at work invigorated and full of ambition, we trust. This seems an appropriate time to call attention to some of the new books added to the library which may add impetus to the usual autumn fire and zeal.

Stuart-Harris, C. H. **Influenza and other virus infections of the respiratory tract.** London, Arnold, 1953.

A timely subject which should be of special value to the alert "G.P." Knowledge of virus diseases is steadily accumulating and this summary of what is known and what is still vague and nebulous should be most useful to the busy doctor who hasn't the time to wade through quantities of journal articles.

Gertler, M. M., and White, P. D. **Coronary heart disease in young adults.** Cambridge, Harvard Univ. Press, 1954

"A mass of new information, leading to important new insights, is presented in this book, which summarizes the findings of a multidisciplinary investigation at the Massachusetts General Hospital of coronary heart disease in adults under 40."

Burch, G. E., and others. **Spatial vectordardiography.** Phila., Lea & Febiger, 1953.

Goodale, R. H. **Clinical investigation of laboratory tests.** 3rd ed. Phila., F. A. Davis, 1954.

Collens, W. S. **Peripheral vascular diseases; diagnosis and treatment.** Springfield, Thomas, 1953.

Duke-Elder, W. S. **Text-book of ophthalmology; vol. 6: Injuries.** St. Louis, Mosby, 1954.

The long-awaited sixth volume of this definitive work.

Ingalls, R. G. **Tumors of the orbit and allied pseudo tumors.** Springfield, Thomas, 1953.

Mushin, W. W., and Rendell-Baker, L. **Principles of thoracic anesthesia; past and present.** Springfield, Thomas, 1953.

Discusses the pneumothorax problem and its solution, historical background, and methods in use today.

Moore, D. C. **Regional block.** Springfield, Thomas, 1953.

Tanner, F. W., and Tanner, L. P. **Food-borne infections and intoxications.** 2d. ed. Champaign, Garrard press, 1953.

Roueché, B. **Eleven blue men and other narratives of medical detection.** Boston, Little, 1953.

Twelve lively stories of mystery and suspense in which the detectives are doctors—medical inspectors, epidemiologists or research scientists—and the criminals, for the most part, microbes. Two of the stories won the Lasker Foundation award for medical reporting.

Stanbury, I. B. **Endemic goiter.** Cambridge, Harvard Univ. press, 1954.

Manual of clinical mycology. 2d. ed. Phila., Saunders, 1954.

Wittkower, E., and Russell, B. **Emotional factors in skin diseases.** N. Y., Hoeber, 1953.

Shelley, W. B., and Crissley, J. T. **Classics in clinical dermatology.** Springfield, Thomas, 1953.

A biographical sketch of the writer introduces each original description by outstanding dermatologists, past and present. All foreign writings have been translated into English. Beginning with Robert Willan's "On cutaneous diseases," 1798–1808, it ends with the description of "Tropical anidrosis" by Allen and O'Brien in

1944. In many cases, originals from which these classics were taken are available in the Faculty Library.

Duffy, J. **Epidemics in colonial America.** Baton Rouge, La. State Univ. press, 1953.

The first comprehensive study of colonial epidemics since Noah Webster's.

Penfield, W., and Jasper, H. **Epilepsy and the functional anatomy of the human brain.** Boston, Little, 1954.

Haymaker, W., ed. **The founders of neurology.** Springfield, Thomas, 1953.

One hundred and thirty-three biographical sketches prepared for the Fourth International Neurological Congress in Paris. Members of the Medical and Chirurgical Faculty who have contributed sketches to this volume are Doctors David Bodian, on Wickman; W. Horsley Gantt, on Pavlov; and A. Earl Walker, on Elliott Smith, Walter Dandy, and Victor Horsley.

Williams, Roger J. **Free and unequal.** Austin, Univ. of Texas press, 1953.

An internationally-known biochemist discusses the real basis of individual liberty, the extent and character of individual differences. He believes that abandonment of the false concept of "the average man" opens up new vistas in education, medicine, art, religion, race and politics. One of the most stimulating and thought-provoking books we have come across in some time.

Gronowicz, A. **Bela Schick and the world of children.** N. Y., Abelard-Schuman, 1954.

This biography of the famous discoverer of the Schick test is a warm and human story written with great charm and appeal. Dr. Edwards A. Park says, in his epilogue, that Bela Schick "is so simple, open and friendly . . . so good and kind that to become acquainted with him is to love him." After reading this book you will feel that you do indeed know and love him.

Health Departments

BALTIMORE CITY HEALTH DEPARTMENT

Birth Record Correction Advisory Service

Since August, 1950 the Bureau of Vital Records of the Baltimore City Health Department and the Legal Aid Bureau of Baltimore jointly have maintained a special advisory service for the correction of birth certificates. The service is particularly designed to aid in the correction of birth certificates of out-of-wedlock children which involve problems relating to adoption, legitimation and paternity.

The advisory service holds sessions on the second Wednesday of every month from 5:00 to 7:00 P.M. in the office of the Director of the Bureau of Vital Records on the first floor of the Municipal Office Building, Lexington and Holliday Streets.

Persons previously reluctant about coming forward, or fearful of embarrassment or exposure have availed themselves of the opportunity to attend these meetings which are private and confidential. The service is particularly advantageous to applicants who are employed during the day and unable to call during regular business hours at either the Health Department or the Legal Aid Bureau offices.

The facilities of the Legal Aid Bureau are made available to persons in low income groups only; all others are advised to obtain the services of private attorneys.

In four years of operation 1,201 persons have applied for assistance in correcting birth certificates. More than half of these requested aid in situations related to adoption, legitimation, paternity and delayed birth registration. A breakdown of the total for the four year period is as follows:

Adoption	222
Legitimation	214
Paternity	44
Legal change of name	72
On basis of usage	53
Delayed registration of birth	112
Cases referred to other registration jurisdictions	50
Cases referred to Legal Aid Bureau	86
Cases referred to private attorneys	43
Others	305
Total	1,201

For any information concerning this service, telephone Mr. Sidney M. Norton, Director of the Bureau of Vital Records, PLaza 2-2000, Extension 827.

Huntington Williams, M.D.

Commissioner of Health

STATE OF MARYLAND DEPARTMENT OF HEALTH

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, September 3–30, 1954

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS: Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County	6	—	2	1	—	—	6	13	4	—	1	—	—	7	10	1	7	—	2
Anne Arundel	1	—	—	—	2	—	—	2	3	—	—	—	—	—	7	3	11	—	1
Howard	—	—	—	—	—	—	—	2	—	—	—	—	—	—	1	—	2	—	—
Harford	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—
Carroll	—	—	—	1	—	—	—	—	—	—	—	—	—	1	1	—	1	—	1
Frederick	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	1	—	—	—
Washington	1	—	—	—	—	—	—	1	—	—	—	—	—	2	—	—	5	—	—
Allegany	1	—	—	3	1	—	—	—	—	—	—	—	—	—	6	—	—	—	1
Garrett	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Montgomery	1	—	1	7	2	—	3	3	3	—	4	—	1	—	1	—	4	—	2
Prince George's	—	—	—	—	—	—	2	6	1	—	5	—	—	—	8	1	9	m-1	1
Calvert	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Charles	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1	—	—	—	1
Saint Mary's	—	2	—	2	—	—	—	—	—	—	—	—	—	4	1	—	—	—	1
Cecil	—	1	1	2	1	—	1	1	2	—	—	—	—	—	2	—	3	—	1
Kent	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Queen Anne's	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Caroline	—	—	—	—	—	—	—	—	1	—	—	2	—	1	2	—	2	—	—
Talbot	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1	—	—	—
Dorchester	—	—	—	—	—	—	—	1	—	—	—	—	—	—	2	—	3	—	—
Wicomico	—	—	2	—	—	—	—	1	—	—	1	—	—	—	6	—	15	—	1
Worcester	—	—	—	—	—	—	1	—	—	—	—	—	—	—	3	—	1	—	—
Somerset	—	—	—	—	—	—	7	—	—	—	—	—	—	—	—	—	2	t-1	—
Total Counties	10	3	6	18	6	0	21	31	14	0	11	2	1	15	55	7	70		12
Baltimore City	1	0	5	4	5	1	13	10	15	0	7	0	0	33	101	4	519		4
State																			
Sept. 3–30, 1954	11	3	11	22	11	1	34	41	29	0	18	2	1	48	156	11	589		16
Same period 1953	17	1	9	11	26	2	52	77	58	3	19	3	0	51	161	14	747		38
5-year median	15	1	6	—	22	2	37	110		7	23	3	3	62	195	27	697		29
Cumulative totals																			
State																			
Year 1954 to date	2990	13	296	705	11364	27	2712	86	62	19	1301	15	5	698	1667	133	5746		385
Same period 1953	2796	10	1426	396	1489	60	2244	221	180	23	2188	24	9	296	1805	111	6156		574
5-year median	3043	23	944	—	4192	44	1531	233		53	885	24	31	462	2113	328	5685		447

m = malaria, contracted outside the U. S. A.
t = tularemia.

Blue Cross - Blue Shield

WHAT PRICE HEALTH?

PAUL D. CARRE*

Everyone you meet, nowadays, knows something about how much it costs to be sick, and most people know that there are numerous voluntary health insurances, non-profit as well as commercial, available to those who want to budget for the hospital and medical expenses they may face.

What progress have we made as a nation during the past twenty years toward protecting ourselves against the unpredictable costs of illness? And what, in fact, are American families doing to meet these costs today? Those of us who provide hospital-medical services or insurance-type benefits naturally have a vital interest in the answers to both of these questions.

The Health Information Foundation, a non-profit organization supported by the pharmaceutical and allied industries, has recently published a preliminary survey based on field work conducted by the National Opinion Research Center during July 1953 covering the twelve prior months. Here, only briefly, is what this comprehensive survey uncovered.

The survey dwelt first upon the actual extent of voluntary health insurance as of July 1953, and came up with the fact that 87 million people, or 57 per cent of the population, were enrolled under some kind of hospital insurance program. People who had protection for surgical and medical expenses numbered about 74 million, or 48 per cent of the population.

Next, the survey broadened its inquiry by breaking these totals down, first to find out who was enrolled, and second, to find out where, economically and geographically, these insured people were concentrated. More people were found to be enrolled in the Northeast and the North Central regions of the country than in the South and the West. By occupation, those employed in "rural" industries had the lowest proportion enrolled, whereas enrollment among people employed in "urban" industries ranged as high as 90 per cent. For one reason or another, the self-employed had the least enrollment anywhere.

By family income, 41 per cent of the families earning less than $3,000 had some insurance, 71 per cent of the so-called middle income families had coverage, and the highest proportion (roughly 80 per cent) was indicated for families earning more than $5,000. Altogether, 80 per cent of all insured persons were enrolled through groups.

If this many people had health insurance, what were the expenditures for personal health services and how much did these people spend on insurance premiums or subscription charges? The total annual charges for personal health services during the survey year amounted to $10.2 billion for all families in the United States. Averaged, these charges came to approximately $207 per family, including the amount paid out for insurance coverage.

Among all families receiving hospital insurance benefits, half had 89 per cent or more of their gross hospital charges covered. And among the families receiving surgical benefits, half had 75 per cent of their gross surgical charges covered. Altogether, insurance benefits amounted to $1.5 billion, or 15 per cent of the total expenditures.

Next, the survey considered the utilization of personal health services and, coincidentally, the utilization of voluntary health insurance during the survey year. Generally, the hospital admission rate for all families was 12 per 100 persons per year. People with insurance had a somewhat higher rate (13 per 100) than those without insurance (10 per 100). The average length of stay for all persons hospitalized was 9.7 days, with virtually no difference between those with insurance and those without insurance.

The number of surgical procedures per 100 persons per year for all families was *six*; among insured families the rate was *seven*, and among the uninsured families the rate was *four*. The survey concludes that, as with hospital insurance, surgical insurance tends to increase utilization. The survey points out that for some people at least insurance is the dividing

* Executive Assistant, Maryland Hospital Service, Inc., and Maryland Medical Service, Inc.

line between "must" or emergency surgery and "elective" surgery.

Up to this point, the Health Information Foundation survey centered upon the vital play between hospital and medical costs on the one hand and, on the other, the impact of voluntary health insurance upon these costs and upon the services provided. And although insurance benefits have obviously cut into overall out-of-pocket expenditures, it is apparent from the survey that medical indebtedness still exists.

Among all families in the United States, 15 per cent were believed to have a total debt of $900 million to hospitals, physicians, dentists and others who render services. In absolute terms, according to the findings, this would mean that roughly 7.5 million families have a medical debt averaging $121 per family, omitting the secondary debts to individuals and financial institutions.

Admittedly, these facts and figures deserve more thorough discussion than this article permits. Many, many factors are involved. And the final report is still being prepared by the Health Information Foundation. But even now, it would seem that these preliminary findings have meaning for those of us in the field.

Ancillary News

PHARMACY SECTION

BASIC FACTS UNDERLYING THE PHYSICIAN'S PRESCRIPTION[1]

JOSEPH COHEN, PHAR.D.[2]

When handed a prescription by your physician, have you ever thought of the many important facts and complex situations which underlie it? Of all the pieces of paper which pass through your hands, perhaps none has a more vital relationship to your physical well being than the physician's prescription. In a sense, it is merely a scrap of paper, but one which plays a highly significant part in your health, and in the health of one-hundred-sixty million people who make up our population.

First of all, what is a prescription? A prescription is a written order for a drug, or drugs, upon which the physician relies for the cure, alleviation, and mitigation of disease. It represents the physician's best judgment after he has made his diagnosis. The prescription represents his mature, professional opinion with respect to treatment, and reflects his view not only of the patient's need, but of all the facts and conditions which form his conclusions as to the drugs to be used, the cautions to be observed, and the conditions to be met.

Physicians write about five hundred million prescriptions a year, which means that more than three prescriptions are written annually for every man, woman and child in our country. This number gives you some idea of the immensity of medical care and of the part the prescription plays in making it effective.

This also means that for five hundred million times a year the medical profession is called upon to minister unto the sick and ailing and to utilize the prescription as a means toward restoring health.

As you might surmise, the filling of the prescription is by no means a perfunctory matter. Indeed, the law of this state requires that all prescriptions be filled by a registered pharmacist, or by some person acting under his personal or immediate supervision.

The legislature of this State long since recognized the importance of the prescription, and has sought to surround it with every possible safeguard. Among these safeguards are the legal, educational, and experience requirements, which the legislature has written into the State Pharmacy Act, and which every pharmacist must meet before he becomes registered.

The law requires that every pharmacist be a graduate of a college or university which gives a course of four college years in pharmaceutical subjects. The curriculum includes general inorganic chemistry, organic chemistry, biochemistry, theoretical and applied pharmacy, pharmacology, pharmaceutical chemistry, and many other subjects essential to a full understanding of drugs and medicines, and which contribute to making the student a safe and competent pharmacist.

But the state is not satisfied merely to prescribe four years of university or college training in pharmaceutical subjects. It has established an examining board to test the fitness of the pharmacy graduate actually to provide a competent pharmaceutical service. This board conducts written and laboratory examinations in those subjects which the board con-

[1] Maryland Pharmaceutical Association. Radio Broadcast over Station WFBR on Sunday, August 1, 1954.

[2] Executive Secretary.

siders essential to its purpose. These examinations cover four or five days, and are devoted to practical and searching means of determining that the college graduate is actually qualified for the obligations and responsibilities which underlie safe and competent professional service.

But the conditions which the pharmacist must meet do not end here. Under the terms of the State Pharmacy Act, every pharmacy in this State must have on hand at all times the technical equipment and apparatus which the State Pharmacy Board has declared essential for the filling of prescriptions and the handling of drugs and medicines.

It is worthy of note that in the Maryland State Health Department there is a division of drug control, the function of which is the maintenance of close supervision over retail pharmacies to see to it that the terms of the pharmacy laws are observed, and that the safeguards which the legislature has thrown around the practice of pharmacy are fully recognized and diligently provided.

Indeed, the State has been most careful in its efforts to assure the people of Maryland adequate and competent pharmaceutical service by requiring pharmacists to complete a serious period of study and to give ample evidence of their fitness to assume the duties of a professional pharmacist.

But, what about the drugs which the physician prescribes and which the pharmacist dispenses? This is an interesting question, and opens up a wide vista of professional and scientific interest. We are living in the era of the miracle drugs, and of those other therapeutic agents which have raised medical care to such an exalted position. We are living in an era marked by the conquest of many ancient maladies which, up to a few years ago, defied medical treatment.

We are living in an era, too, marked by profoundly important progress in such diseases as cancer, tuberculosis, diabetes, cardiac disease, and the ills of the aged. Indeed, it would be difficult for those most expertly versed in scientific progress in the cure and treatment of disease to over-estimate the gains which have been made.

The drug industry deserves much credit for the highly gratifying conditions which prevail throughout medical care. To bring this statement into focus, what good would be the discovery of insulin if there had not been an industry capable of producing this life-saving drug in sufficient quantity and at a price within the reach of everyone? What benefits could have come from penicillin, had not the drug industry expended vast sums for the building of highly specialized equipment from which this product would come in sufficient quantity and at a satisfactory price?

Indeed, the education of the physician and the education of the pharmacist would be largely dissipated so far as its usefulness is concerned were it not for the drug products which the manufacturing drug industry provides. The drug industry is, in every sense of the word, a public health industry, and must be looked upon as an integral part of the medical care team.

Recent studies have shown that the industry spends more than one hundred million dollars a year on research devoted entirely and exclusively to the discovery of newer and better drugs and medicines, and for the improvement of those long in use.

So efficient and productive has this research been that today, as much as eighty-five per cent of the drugs and medicines prescribed by physicians have become available within the past ten or fifteen years. This is a highly significant statement, because it affords ample proof that the medical profession does not hold onto drugs and medicines when newer and better ones become available. It also shows that the drug industry does not seek to perpetuate old drugs, when newer and better ones come from their scientific research laboratories.

In virtually every one of our large manufacturing plants are to be found extensive research laboratories thoroughly and completely equipped with the most modern scientific apparatus essential to their needs. These laboratories are staffed by scientists of world wide reputation who devote their entire time and energies to the discovery of more effective weapons in the fight against disease.

While the drug industry must be considered as an integral part of the medical care team, it must also be seen as pharmacy on a grand scale, as the complex operations and procedures required in the production of modern drugs and medicines are merely an amplification of those methods and procedures which the pharmacist must employ in the filling of prescriptions and the safe handling of drugs and medicines.

650 West Lombard Street
Baltimore 1, Maryland

LIFE IN A GOLDFISH BOWL

ELIZABETH D. WHETSELL

Some of us are wives of specialists, some are wives of general practitioners, some of health officers, some of retired medical men, or perhaps army officers. Some of us have lived in small towns and some in cities. But no matter where we live or in what capacity, we are all doctors' wives, and wives in that respect at least of public servants.

Whether we are retiring and home-loving, or club-minded and extroverts, we are still judged and observed on the basis of being our husbands' wives. It is something rather like living in a goldfish bowl and sometimes very discouraging to realize how prone the public is to pounce on doctors' families for their frailties. Sometimes this realization comes the hard way, when a new doctor's wife may mean everything the right way, with no hidden meaning, no medical interpretations, no confidences betrayed. But it takes a short while to learn that you no longer speak as yourself, casually, but as the doctor's wife, to be quoted, requoted, or *misquoted*, according to the charitability of the quoter!

We must consider ourselves, then, in relation to our husbands' profession rather than just as anybody's wife. We must be careful of our attitudes towards patients and non-patients, others in the profession, and other doctors' wives. There is so much politics and so much self-seeking in *every* walk of life today, so many small-minded people among whom jealousy arises easily. And it is undoubtedly hard for doctors themselves to face, overcome, or ignore some of these attitudes. We, as members of the medical auxiliary, want to help the doctors as a whole, or else we have no excuse for being organized. Should we not then begin by being helpful to our individual doctors? When little things come up to discourage them, when circumstances combine to baffle them as to other people's actions and reactions, it is to us at home that they turn for reassurance. Are we always capable of giving it to them? When their dispositions are worn thin by the stress of "ornery" sick people, are we ready to understand at home that they must use us as escape valves? When they are too tired or too occupied to go out with us socially, as perhaps we have planned, are we able to minimize the disappointment and accept the upset of our plans? Are we big enough to overcome woman's proverbial "catty" tendency (whether that is a deserved proverbiality or not!) and be charitable toward those who cause some of the irritations and upset plans?

Finally, if we know of any doctor who is unethical and grasping, or any doctor's wife who is jealous and grudging of success in others, can we possess our soul in patience while we realize that they are their own worst enemies, and that *right* attitudes and activities *will* triumph in the end?

When national conventions and correspondence, and organized medical groups urge us to talk for our husbands against socialized medicine, I have the feeling that talking is not the only thing for us to do. I believe that *living* our convictions, if we live them steadfastly enough, is the best way to show the non-medical public that our doctors are what the public wants now and that they are always striving further to maintain the *best* relations and give the *best* service to an ailing clientele. When the layman makes an unkind remark about doctors "making money," not knowing how much of their very life-blood goes into the earning of the money, could we not ask ourselves, individually, if we *do* put too much stress on money-making in our family. If we honestly feel that we are not mercenary—and few of us are—then we should simply forget the layman's undeserved remark. Our way of living among our friends and acquaintances will show, better than any arguing words, whether we are as "they say."

All of us can, I'm sure, apply what I have said generally to ourselves in particular instances. And if we are to take a stand against socialized or state-

regulated medicine, I believe the best stand we can take as an organization, is that of a group of right-thinking, right-acting women, who by their example will inspire other people to follow.

AUXILIARY PROGRAM NOTES

Since many Auxiliaries are beginning the year and planning programs, a quick review of the type program we might include in our schedule seems appropriate. Mrs. George Turner, National President, has recommended "Health Service in Communities" as a program starter for this year. Do you know the health services available in your community? Have you helped with any of these services? Are there any new services? What health services are provided by your State Board of Health, local Health Department and School Health Department?

Your State and National Auxiliary will help you plan programs on Nurse Recruitment; Civil Defense; National and State legislation relative to health problems and medical education; the A. M. A., its history, functions and various councils and bureaus; "Today's Health" magazine; the World Medical Association; World Health Organization, and the Student American Medical Association.

For Civil Defense get someone to review Philip Wylie's "Tomorrow" which is excellent recommended reading for all members. It tells the story, dramatically, of the difference between a prepared and unprepared community under an enemy bomb attack. The characters all seem real and have all our very human excuses and lethargy.

Help Pass Along Medicine's P. R. Message!

Four new pamphlets are available, without charge, from the A. M. A., 535 North Dearborn Street, Chicago 10, Illinois:

1. "Quack!" (explains the dangers of consulting quack healers),
2. "Health Today!" (reviews medical progress since 1900),
3. "On Guard!" (explains how the A.M.A. evaluates drugs),
4. "Why Wait?" (tells the best way to select a family doctor).

Use these pamphlets when you have the opportunity at fairs, health forums, schools, public meetings, as mail stuffers, *in doctors' reception rooms*, in reading racks in libraries and hospitals.

A. M. A. Films: Available for TV audiences and for showing on 16 m.m. sound film projectors to clubs, schools, churches, etc.

1. "Operation Herbert"—humorous and instructive film on medical costs today. Approximate time, one-half hour.
2. "A Life to Save"—the necessity of receiving expert medical care. Time, 27 minutes. For TV showing, only until March 1. Write A. M. A. Film Library, 535 North Dearborn Street, Chicago 10, Illinois.

TEN WAYS TO KILL AN AUXILIARY*

1. Don't go to the meetings.
2. If you go, be late.
3. Should you go out of curiosity, make a point of leaving early. This always encourages those who have worked to make a program interesting or a social hour pleasant.
4. If you do attend a meeting, find fault with the work of the officers and members.
5. Never accept office. It is easier to criticize than to do things.
6. Get sore if you are not appointed on committees but if you are, do not attend committee meetings.
7. If asked by the chairman to give your opinion on some matter, tell her you have nothing to say. After the meeting tell everyone how things should be done.
8. Do nothing more than absolutely necessary, but when members use their ability to help matters along, howl that the institution is run by a clique.
9. Hold back your dues, or don't pay at all.
10. Don't bother about getting new members. (sic) "Let Ruth do it."

* Reprinted by courtesy of "The Quarterly Bulletin," Woman's Auxiliary to the Missouri State Medical Association.

Book Reviews*

Peripheral Circulation in Man. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., B. Ch., and Jessie S. Freeman, M.B., B.S., D.P.H., 1954, Little, Brown and Company, Publishers, 219 pages. Illustrated. $6.00.

A Symposium on "Peripheral Circulation in Man" was given in May 1953 under the sponsorship of the Ciba Foundation, London. This volume contains the excellent papers presented at that time along with discussions of these reports. Much of the information obtainable from this book is not easily available elsewhere and much previously unpublished work is reported by the discussors.

The various methods available for the measurement of human peripheral blood flow are surveyed. The chapters on the secretion of adrenalin and nor-adrenalin and their effects on blood flow through human skeletal muscle present some newer findings in the pharmaco-physiology of peripheral blood vessels. The effects on circulation following exposure to heat or to cold, the results of sympathectomy, and the possible importance of cold agglutinins are among the numerous problems concerning the peripheral circulation included in this symposium.

E. R. S.

* The reviews here published have been prepared by competent authorities and do not represent the opinions of any official bodies unless specifically stated.

EDITORIAL SURVEY OF REINSURANCE BILL

A. M. A. Secretary's Letter

There was considerable discussion and controversy among some members of the profession relative to the editorials which appeared in the nation's press after the House "killed" the administration's reinsurance bill by an overwhelming majority. To gain a clearer picture of how the newspapers felt about the House action, the A.M.A. Public Relations department made an analysis of the editorial reaction and here, factually, is what it found:

During a three weeks' period, following House action, the A.M.A. received editorials from 65 newspapers which represent 3.5 per cent of the nation's 1,785 daily papers.

Only 15 of the papers, with a total circulation of 2,361,095, were critical of the A.M.A. for its opposition to the reinsurance bill.

Five newspapers, with a total circulation of 301,781, commended the A.M.A. for taking a strong stand against the bill.

Thirty-five of the newspapers, with a combined circulation of 4,746,912, spoke out in favor of the reinsurance bill.

Sixteen papers, with a combined circulation of 817,465, opposed the administration for fostering such a bill.

Fourteen newspapers, with a circulation of 1,173,447, discussed the reinsurance bill, editorially, but remained neutral.

The total circulation of the 65 newspapers, whose editorials on the bill were analyzed by the A.M.A. is 8,774,413 which is only 16.1 per cent of the total national circulation of newspapers.

Coming Meetings

ANESTHESIOLOGY SECTION

CHARLES F. HOBELMAN, M.D., *Chairman* LIONEL GLASSMAN, M.D., *Secretary*

Tuesday, November 2, 1954, 8:00 p.m.

Deutsches Haus, Room 14, 1212 Cathedral Street

Discussion of the Annual Meeting of the American Society of Anesthesiologists held October 25 to 28, in Cincinnati, Ohio.

OTOLARYNGOLOGICAL SECTION*

ALBERT STEINER, M.D., *Chairman* WALTER E. LOCH, M.D., *Secretary*

Hopkins Club

Tuesday, November 9, 1954

Dinner Meeting 6:00 p.m.

PEDIATRIC SECTION*

JOSEPH M. CORDI, M.D., *Chairman* SAMUEL S. GLICK, M.D., *Secretary*
HAROLD E. HARRISON, M.D., *Vice-chairman*

Tuesday, November 9, 1954, 8:30 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Recent Advances in the Knowledge of Disorders of Blood Coagulation. (Illustrated.) MILTON S. SACKS, M.D.

The Significance and Diagnosis of Systolic Murmurs in Children. (Illustrated.) SIDNEY SCHERLIS, M.D.

Discussion from the floor following the speakers.

* Section of the Baltimore City Medical Society.

JOINT MEETING RADIOLOGICAL SECTION AND THE CHEST SECTION*

JOHN DECARLO, JR., M.D., *Chairman* — JOHN E. MILLER, M.D., *Chairman*
PAUL W. ROMAN, M.D., *Secretary* — EDMUND G. BEACHMAN, M.D., *Secretary*

Veterans Administration Hospital
The Alameda and Loch Raven Boulevard

Tuesday, November 16, 1954

Film Reading Session 5:30 p.m. — Dinner 6:30 p.m.

Scientific Session 8:00 p.m.

Thoracic Abnormalities Which Occur in General Diseases of the Body. Coleman B. Rabin, M.D., Assistant Clinical Professor of Medicine, College of Physicians and Surgeons, Columbia University.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty.

RICHARD W. TELINDE, *Chairman* — BEVERLEY C. COMPTON, M.D., *Secretary*

Thursday, November 18, 1954, 5:00 to 6:00 p.m.

1211 Cathedral Street, Baltimore

OPHTHALMOLOGICAL SECTION*

FRED M. REESE, M.D., *Chairman* — HERMAN K. GOLDBERG, M.D., *Secretary*

Hopkins Club

Friday evening, November 19, 1954

Dinner 6:15 p.m. — Meeting 8:00 p.m.

Diagnosis of Intraocular Tumors. WILLIAM F. HUGHES, JR., M.D.

* Sections of the Baltimore City Medical Society

DERMATOLOGY SECTION*

RAYMOND C. V. ROBINSON, M.D., *Chairman* WILLIAM R. BUNDICK, M.D., *Secretary*

Monday, November 22, 1954, 8:30 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Dermatologic Experiences at a Hospital for the Mentally Retarded. (Illustrated.) ISRAEL ZELIGMAN, M.D., AND SAMUEL P. SCALIA, M.D.
Discussion by LEON GINSBURG, M.D.

The Use of Staphylococcus Toxin in Dermatology. HANFORD H. HOPKINS, M.D.
Discussion by HARRY M. ROBINSON, SR., M.D.

Election of Officers to be held.

ORTHOPAEDIC SECTION*

ALLEN F. VOSHELL, M.D., Chairman WILLIAM P. HORTON, M.D., *Secretary*

Monday, November 29, 1954, 8:00 p.m.

Children's Hospital School

Subject to be announced.

THE EASTERN SECTION OF THE AMERICAN TRUDEAU SOCIETY

Sheraton Park Hotel, Washington, D. C.

October 22–23, 1954

Registration 9 a.m., October 22, 1954 Scientific Program to follow.

Invitation is extended to those interested in diseases of the chest, tuberculosis, and cardiology. For additional information contact: Dr. Hugh G. Whitehead, 1201 North Calvert Street, Baltimore 2, Maryland.

* Section of the Baltimore City Medical Society

NATIONAL REHABILITATION ASSOCIATION TO MEET IN BALTIMORE, OCTOBER 24–27

The annual meeting of the National Rehabilitation Association will be held at the Lord Baltimore Hotel October 24–27. The program on October 25 at 2 p.m. "Maximum Rehabilitation of the Severely Handicapped" will be of particular interest to physicians. This program will be a series of case demonstrations of rehabilitation of the bilateral arm amputee, cord lesion with paraplegia, bilateral leg amputee, paralysis of both legs and one arm, rheumatoid arthritis, and cleft palate and lip. Cases will be discussed by: Dr. Donald Covalt, Physiatrist, Clinical Director, Institute of Physical Medicine and Rehabilitation, New York City; Dr. Robert L. Harding, Plastic Surgeon, and Medical Consultant to the Pennsylvania Bureau of Rehabilitation, Harrisburg, Pennsylvania; Dr. Cloyd S. Harkins, Dental Surgeon, and Director of the Philipsburg Cleft Palate Clinic, Osceola Mills, Pennsylvania; Dr. William Harkins, Dental Surgeon, Associate Director of the Philipsburg Cleft Palate Clinic, Osceola Mills, Pennsylvania; Dr. Roy M. Hoover, Orthopedic Surgeon, and Medical Director of Woodrow Wilson Rehabilitation Center, Fishersville, Virginia.

HIGH BLOOD PRESSURE PROCEEDINGS AVAILABLE THROUGH HEART ASSOCIATION OF MARYLAND

Proceedings of the 1953 Annual Meeting of the Council for High Blood Pressure held by the American Heart Association are now available in a cloth bound, 96 page hard covered monograph through your State Heart Association at $2.00 per copy. All requests should be directed to the Heart Association of Maryland, 221 E. 25th Street, Baltimore 18, Maryland—Attention: Lee Bowers, Director of Education.

Intended primarily for internists, cardiologists and investigators in the field of hypertension, it includes five scientific reports of original investigative work concerning developments in the field of high blood pressure research.

The brief reports, which deal with relations between endocrine secretions and electrolyte and fluid balance and hypertension, were presented by authorities who summarized their own recent work and the investigations of others in the field. The book compiles in one convenient reference volume material which otherwise is scattered throughout the medical literature.

Contributors to the volume include Dr. R. W. Sevy, of the University of Illinois, who reports on the influences of anterior pituitary gland and the adrenal cortex on experimental hypertension; Dr. Georges M. C. Masson, of the Cleveland Clinic, who reviews an experimental series on the role of renin in experimental hypertension; and Dr. Simon Rodbard, of the Medical Research Institute at Michael Reese Hospital. Dr. Rodbard discusses salt-water balance and body mechanisms in relation to hypertension.

The changing patterns of sodium metabolism in hypertension are described by Dr. D. M. Green, of the University of Southern California. Dr. George Perera of Columbia University reporting on the role of metabolism in essential hypertension, discusses the possibility of a steroid, or steroid relationship, being a basic factor in the disease.

The 1953 Proceedings is the second volume in a projected series. The first volume, the Proceedings of the 1952 meeting, is still available, at a cost of $1.75, paper bound.

MEETING OF THE SOUTHERN MEDICAL ASSOCIATION

The Southern Medical Association will meet in St. Louis, Missouri, November 8–11, 1954.

POSTGRADUATE COURSES

CARDIOLOGY

A SERIES OF PANEL DISCUSSIONS
OSLER HALL, 1211 CATHEDRAL STREET

Thursday, November 4, 1954, 8:30 p.m.
Myocardial Infarction. Samuel Whitehouse, M.D., Moderator.

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Friday, November 12, 1954, 8:30 p.m.
Arrhythmias. E. Cowles Andrus, M.D., Moderator.

***

Friday, November 19, 1954, 8:30 p.m.
Peripheral Vascular Diseases. George H. Yeager, M.D., Moderator.

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Friday, November 26, 1954, 8:30 p.m.
Congenital Heart Disease. Alfred Blalock, M.D., Moderator.

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These courses are given under the auspices of the Baltimore City Medical Society, its Sections, and the Maryland Academy of General Practice. A cordial invitation is extended to all members of the Medical and Chirurgical Faculty to attend these courses. There will not be a course in December, but there will be one on "Pediatrics" in January and the information will be published in the December issue of this JOURNAL.